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**Understanding teenage perceptions towards breastfeeding: a study of
college students using focus groups and questionnaires**

Rebecca Karen Jones

Dissertation submitted to the University of Chester for the Degree of
Master of Science in part fulfilment of the Modular Programme in Health
Promotion.

August 2006

ABSTRACT

BACKGROUND: There is extensive evidence showing that breastfeeding makes a major contribution to infant health and development. Breastfeeding has a vital contribution to make towards reducing health inequalities in the UK, with breastfeeding remaining more prevalent among older, more educated and socially advantaged women. Health promotion initiatives are driven by the Department of Health's goals of increasing breastfeeding initiation rates by 2% annually and reducing inequalities in health with particular focus on women from disadvantaged groups. However despite these efforts, breastfeeding rates in the UK remain the lowest in Europe.

AIM: This study aims to understand the perceptions of teenagers towards breastfeeding in a Sure Start area where bottle-feeding is deeply entrenched. It investigates the students' attitudes and beliefs of breastfeeding but also their normative standards and values of breastfeeding.

METHOD OF RESEARCH: The chosen method of research was using focus groups and self-completion questionnaires. Three focus groups were conducted to generate definite themes to which the questionnaires were designed. The selected sample consisted of 72 teenagers between the ages of 14-20 attending courses within the Health and Social Care and Business Departments within a Shropshire College of Further Education.

FINDINGS: The majority of students, 62.5% believe that breastfeeding is a natural way to feed a baby though only 34% plan to breastfeed. The key themes identified to influence the students perceptions of breastfeeding were: intergenerational normative pressures; lack of knowledge of the benefits of breastfeeding; witnessing breastfeeding; and bottle-feeding being perceived as having less adverse reactions such as embarrassment and exclusion.

CONCLUSION: This study identified that health promotion initiatives should target breastfeeding education in schools and colleges, as evidence suggests knowledge is gained and valued positively by the pupils. The research also addressed the wider societal issue with breastfeeding; strategies should be in place to improve better facilities for breastfeeding in public so that breastfeeding is seen, supported and viewed as part of the normal process of life so family and societal influences do not undermine a women's decision to breastfeed.

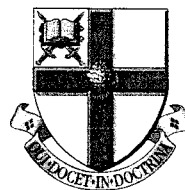
DECLARATION

‘The work is original and has not been submitted previously in support of any qualification or course’

Signed.....Date.....

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23 August 2006



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I have considered your request in relation to the guidelines in the 2005 – 2006 dissertation module handbook on Page 6, Section 7 which reads:

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- 2 To edit further from these chapters would reduce the explanations and interpretations of the research process and the research findings.

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Acknowledgements

I wish to acknowledge the contribution staff of the University of Chester have made towards this dissertation. In particular, I would like to thank my supervisor Dr Elizabeth Mason-Whitehead who has given me tremendous support and encouragement and kept me enthused through my years studying Health Promotion at Chester.

I would also like to thank Sure Start Oswestry who funded 2 years of my studies and continued to support me throughout this time.

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LIST OF ABBREVIATIONS

BFHI	Baby Friendly Hospital Initiative
BFN	Breastfeeding Network
CEDW	Convention on the Elimination of All forms of Discrimination against Women
DOH	Department of Health
HDA	Health Development Agency
IMD	Index of Multiple Deprivation
NESS	National Evaluation of Sure Start
NICE	National Institute of Clinical Excellence
NHS	National Health Service
LREC	Local Research Committee
PCT	Primary care Trust
RCN	Royal College of Nursing
SPSS	Statistical Package for Social Sciences
WHO	World Health Organisation

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CHAPTER 1 INTRODUCTION

The World Health Organisation has recognised the challenge of promoting guidance for feeding infants and young children as a fundamental issue of global concern. The importance of nutrition and nurturing during the first three years of life are crucial for lifelong health and well-being (WHO 2003). The Global Strategy on *Infant and Young Child Feeding* (2003) states that infants should be exclusively breastfed for the first six months of life as 'Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants' (WHO 2003 Chapter 10 p.7). The reality is however, that globally barely 40 per cent of mothers' breastfeed during this crucial period (UNICEF 2005).

Research has estimated that if every baby was exclusively breastfed from birth for six months 1.3 million lives would be saved each year and lives would be enhanced without the incalculable emotional and economic cost of illness and death resulting from artificial feeding (UNICEF 2005). Breastfeeding is more than food alone research has proven that exclusive breastfeeding;

...protects babies from diarrhoea and acute respiratory infections, stimulates their immune systems and improves response to vaccinations, and contains many hundreds of health-enhancing molecules, enzymes, proteins and hormones' (UNICEF Retrieved May 3, 2005 from http://www.unicef.org/nutrition/index_breastfeeding.html)

There is no gift more precious a mother can give to her infant than breastfeeding regardless of where they live (WHO 2003). Children who are breastfed have lower

rates of childhood cancers, are less susceptible to pneumonia, asthma and diabetes and studies now suggest that breastfeeding is good for neurological development (UNICEF 2000). Breastfeeding also offers the immeasurable benefit of bonding ‘the natural opportunity to communicate love at the very beginning of a child’s life.... laying the foundation for a caring and trusting relationship between mother and child’ (UNICEF 2000 p.1).

For the poorest of nations exclusive breastfeeding offers a hygienic source of energy, is unlikely to be contaminated and contain immune factors that are protective as well as giving the essential nutrients and water for healthy growth and development (Nwenfu Kakute, Ngum, Mitchell, Kroll, Wangenkeh Forgwei, Ngwang & Meyer 2005).

However researchers have found that in rural Africa it is common practice for women to mix-feed their infants combining artificial formulae feeding and breastfeeding even though their local medical care strongly recommend exclusive breastfeeding (Nwenfu Kakute et al 2005). A recent study suggests that the mothers identified cultural factors as influencing their decision to mix-feed their babies with pressures from Village Elders to supplement feeding being traditional practice with the belief that breast milk is an incomplete food source (Nwenfu Kakute et al 2005). These beliefs carry high risks of additional illness and death, studies indicate that a non-breast fed child living in disease-ridden unhygienic conditions is between six and 25 times more likely to die of diarrhoea and four times more likely to die of pneumonia than a breastfed infant (UNICEF Retrieved May 3, 2005 from http://www.unicef.org/nutrition/index_breastfeeding.html).

Cultural influences also affect infant feeding decisions in the developed world of the USA. Although the cultural groups differ in specifics to African countries the opinion in particular of the maternal grandmother and baby's father have a highly predictive effect on the initiation and duration of breastfeeding (Smith and Tully 2001).

Frequently in the United States neither health care providers nor parents seem convinced that the method of feeding matters significantly as formulae feeding is viewed as an acceptable and accessible alternative with the 'mechanics of breastfeeding being considered somewhat mysterious and not always worth the effort to pursue' (Smith and Tully 2001 p.423).

The World Health Organisation recognises the breastfeeding challenge is a reinforcement of a 'breastfeeding culture' protecting, promoting and supporting an environment globally that empowers women to breastfeed (UNICEF 2005). The Convention on the Elimination of All Forms of Discrimination against Women (CEDW 1999) specifies that Governments must ensure 'appropriate services in connection with pregnancy confinement and the post-natal period.... as well as adequate nutrition during pregnancy and lactation' (article 12 CEDW 1999 as cited by UNICEF 2000). This argument also supports that children have a right to good nutrition as was specifically stated during the tenth anniversary of 'The Convention on the Rights of the Child' (1999). The Convention called all nations to inform all segments of society and about child health and nutrition, including the advantages of breastfeeding (article 24 UNICEF 1999).

In 1990 The Innocenti Declaration is considered to be the landmark where a definitive, policy setting document outlined national support and guidance to breastfeeding. These

ambitious new standards with the key objectives for the protection, promotion and support of breast feeding (WHO/UNICEF 1990) was reported at its 15th year anniversary to of saved six million lives annually with global exclusive breastfeeding rates having risen by at least 15 per cent (UNICEF 2005). The Declaration recognised the powerful constraints upon women with regard to choices related to and experiences of breastfeeding (Dykes 2003). The establishment of a multisectoral national breast feeding committee under the Declaration set four targets ensuring that social policy enabled the development of an empowering culture for breastfeeding women (Dykes 2003).

For more than a decade UNICEF and WHO have been working to promote breastfeeding through one of the Innocenti Declaration's four targets, The Ten Steps to Successful Breastfeeding or the Baby-Friendly Hospital Initiative (BFHI). This initiative launched in 1991 was established to ensure that all maternities whether free standing or in a hospital become centres of breast feeding support. The BFHI has now more than 19,000 hospitals in 130 countries (UNICEF 2005) globally and through a series of training manuals and robust assessments aim at:

- Ensuring facilities help mothers begin breastfeeding within half an hour of birth.
- Allow new mothers and their babies to be together 24 hours a day.
- Give infants no food other than breast milk except for medical reasons.

(UNICEF Retrieved May 3, 2005 from

http://www.unicef.org/nutrition/index_breastfeeding.html)

The Innocenti goals (2003) were included and superseded by The Global Strategy for Infant and Young Child Feeding (2003) an emerging policy framework that builds on

the past and continuing achievements of other strategies. The Baby Friendly Hospital Initiative (1991), the International Code of Marketing of Breast milk substitutes and the Innocenti goals protection, promotion and support of breastfeeding (WHO 2003) were of notable importance. This global strategy provides the way forward to overcoming the challenge of providing a 'breastfeeding culture' by adding support and attention for mothers in the community, addressing gender needs and directly improving early childhood survival, growth and development (WHO/UNICEF 2003).

Breastfeeding rates are one of the lowest in the developed world and certainly the lowest in Europe in the UK (Earle 2002). With research indicating that cancers, coronary heart disease and childhood obesity three of the Governments target areas are positively affected by increasing rates of breastfeeding (DOH 2004), breastfeeding has become a major public health concern.

There is also an important equality issue; breastfeeding has a vital contribution to make towards reducing health inequalities in the UK as identified in The Acheson Report (DOH 1998) with breastfeeding remaining more prevalent among older, more educated and socially advantaged women (DOH 2004). The National Infant feeding Survey 2000 indicated that only 46 per cent of women under 20 years and 52 per cent of women who had never worked breastfed in the UK compared to 78 per cent aged 30 and older and 85 per cent of women in higher occupations (DOH 2002). There is a wide body of evidence indicating that the bottle-feeding culture is entrenched by socio-economic deprivation, geography, cultural background and education (Shaw, Wallace and Bansal 2003) and that these incompatible social norms make it difficult for

mothers to breastfeed successfully in the UK (Stewart-Knox, Gardiner and Wright 2003).

There is also the issue of social attitudes in the UK (Hollins 2000). This process of socialisation ‘whereby the individual is moulded into a social being through learning to think and behave according to the values and norms prevalent in his society’ (Thomlinson pp.9-10 as cited by Atkinson, McCarthy and Phillips 1987) defines what kind of behaviour is believed to be appropriate by an individual in different circumstances (Atkinson et al 1987) for example breastfeeding in public. Any public place in the UK today mothers are still being ushered into a toilet to continue breastfeeding (Smale 2001) even with the new millennium seeing an increase in public awareness under the ‘Breastfeeding Friendly Premises Scheme’ mothers still have a cultural unease about breastfeeding in public (McFadden and Toole 2006). It could be argued that the fact that we need a scheme to allow breastfeeding in a public place reveals that breastfeeding is stigmatised and allowance is an ‘entrenched reaction’ (Smale, 2001 p.234).

Norway has high breastfeeding rates with initiation rates at 98 per cent and still 80 per cent breastfeeding at 6months (Gerrard 2001). Breastfeeding is so embedded in the Norwegian society that a mother can feed her baby in almost all situations without a reaction (Smale 2001). It is felt that this is due to the Norwegians relaxed attitude towards the naked body and that barriers that deter women from breastfeeding have been removed (Gerrard 2001). Within the UK societal embarrassment in using the body to breastfeed is a determining factor for mothers not to consider breastfeeding (Stewart-Knox, Gardiner and Wright 2003). As Heath (2001) states ‘embarrassment

lies at the heart of social organisation...it provides a personal constraint on the behaviour of the individual in society and a public response to actions and activities considered problematic or untoward' (Heath 2001 p.60).

This emotion undermines our confidence (Heath 2001) to breastfeed, and in particular young mothers of poor education and low social class breastfeeding can be considered 'disgusting' or 'dirty' (Iniechen, Pierce and Lawrenson 1997) as revealing the breast and nipple is often viewed as 'rude' by children or '..the female equivalent of flashing' (Smale, 2001p.237).

The Government has responded by addressing the health and inequality issues surrounding breastfeeding in a number of DOH documents and initiatives. The *Priority and Planning Framework 2003-2006* (2002) has committed all Primary Care Trusts (P.C.T) to increase their breastfeeding initiation rates by 2 percentage points per year with particular focus on women from disadvantaged groups (DOH 2002). *The infant Feeding Initiative -A Report Evaluating the Breastfeeding Practice Projects 1999-2002* (DOH 2003) have significantly contributed to the Government's understanding of the effectiveness of national and local initiatives to increase breastfeeding. The initiatives have demonstrated that the most marked inequalities in breastfeeding rates are strongly associated with deprivation (Carson 2001).

This research focuses on the perceptions of young people towards breastfeeding in a local project where breastfeeding initiation rates are 13% below the national average (Shropshire County PCT 2005). The term perceptions towards breastfeeding as discussed by Stewart-Knox et al (2003) are defined as being the social drivers of infant feeding decisions. Infant feeding as a health behaviour can be determined by the

intention of an individual (Kasl and Cobb as cited in Bowling 2002) undertaking an activity with the belief that the purpose of the activity is prevention of disease and healthy behaviour (Bowling 2002). The aim of this research is to understand the perceptions of young people towards breastfeeding as a behaviour, and what are the dominant themes that influence these perceptions or intentions to breastfeed. This study is about gaining qualitative and quantitative data from a sample of teenage students to gain an understanding of the dominant themes that affect their perceptions i.e. socio-economic, education and intergenerational and cultural pressures.

CHAPTER 2 LITERATURE REVIEW

The literature review was used as a means to enhance the understanding of the subject and offer comparisons of those investigating the subject (May 2001). It offered guidance to the research question and helped justify each assertion throughout the research process (Bryman 2001). A systematic review of literature regarding breastfeeding was undertaken by focusing on the position of breastfeeding internationally, national interventions and local initiatives that explore the issues affecting perceptions on breastfeeding. These will be broken down into the following sub-headings to give depth to the subject:

Part 1. International Strategies

Part 2. National Intervention

Part 3. Local Initiatives

- i) Inequalities in breastfeeding
- ii) Attitudes and perceptions of breastfeeding
- iii) Infant feeding decisions
- iv) Acceptance of breastfeeding in public places
- v) Intergenerational and cultural pressures of infant feeding

Part 1. International Strategies

International breast feeding strategies are fundamentally directed by the World Health Organisation (WHO) and supported by UNICEF. WHO (1990) recognised the need to reinforce a breastfeeding culture globally with the incursions of a bottle-feeding culture spreading. The Innocenti Declaration was adopted in 1990 and endorsed by the World Health Assembly and UNICEF's Executive board (UNICEF 2005). With the appointment of a national breastfeeding coordinator and the establishment of a multisectoral national breastfeeding committee a definitive, policy-setting document was outlined with the key objectives for the protection, promotion and support of breastfeeding. The Innocenti Declaration including the UK was adopted by 30 governments and set four targets (UNICEF 2005):

- Ten Steps to Successful Breastfeeding or The Baby Friendly Hospital Initiative (BFHI).
- The International Code of Marketing of Breast-Milk Substitutes.
- Legislation protecting the rights of working women with the enforcement of maternity protection.
- An overview of breastfeeding patterns in 1990's as summarised among the World Summit for Children goals.

A recent press release '15 years After Innocenti Declaration' (UNICEF Retrieved February 7th 2006 from http://www.unicef.org/media/media_30011.html) declared that six million lives are saved annually by exclusive breastfeeding, and globally breastfeeding rates have risen by 15% since 1990. UNICEF, WHO and other child survival partners hailed The Innocenti Declaration 1990 as the landmark to this progress. The promises of the Declaration and the Baby Friendly Hospital Initiative in 1990 turned the vast international community of breastfeeding advocates into action,

with nearly 20,000 hospitals in 150 countries now 'Baby Friendly' and 60 countries have laws or regulations implementing the International Code of Marketing of Breast-milk substitutes (UNICEF 2006).

However this press release also reported that the original goals of The Innocenti Declaration are far from met with only 39% of infants in developing countries being exclusively breastfed. The continuing lack of awareness amongst mothers and lack of support from health workers and communities appear largely to blame for this low rate (Nwenfu Kakute et al 2005). UNICEF and WHO now call for greater government action and investment to protect exclusive breastfeeding (UNICEF Retrieved February 7th 2006 from http://www.unicef.org/media/media_30011.html).

An article by Dykes (2003) the 10-year journey of the Innocenti goals protecting, promoting and supporting breastfeeding in the UK is explored. Focusing on The Baby-Friendly Hospital Initiative Dykes (2003) outlines the significant impact The BFHI has had upon the number of women who commence breastfeeding. In 2003 there were 47 health care facilities accredited as 'Baby Friendly' and 75 maternity units or community services with a certificate of commitment (UNICEF UK BFHI, as cited by Dyke 2003). The hospitals accredited as 'Baby Friendly' were showing more than a 10% rise in initiation rates within 4 years of receiving the accreditation, with some of the largest increases occurring in hospitals serving inner city or deprived areas (Dykes 2003).

Overall Dykes (2003) highlights the encouraging trend between the 1995 Infant Feeding Survey and 2000 showing evidence that the social class differential is

narrowing in breastfeeding initiation rates with an increase in the women in socially excluded areas commencing breastfeeding (Dykes 2003).

August 1999 celebrated the ‘Tenth Anniversary of the Convention on the Rights of the Child’ with UNICEF publishing ‘Breastfeeding: Foundation for a Healthy Future’ (UNICEF 1999). This document ‘supports the right to nutrition’ (UNICEF 1999) by promoting The Convention of The Rights of The Child (1999) calling for all segments of society globally to be informed about child health and nutrition, including the advantages of breastfeeding.

The World Health Organisation and UNICEF define the obligations and responsibilities of Governments and international organisations in the ‘Global Strategy on infant and Young Child Feeding’ (2003). The strategy a result of a two-year participatory process aims at critically examining the factors affecting feeding practices for infants and young children. Intended as a ‘guide for action’ it identifies interventions with a proven positive impact in supporting mothers and their families in carrying out their crucial roles. It continues to commit to the UNICEF’s Baby-Friendly Hospital initiative ‘Ten Steps to Successful Breastfeeding’ launched in 1991, implementing the International Code of Marketing of Breast-Milk substitutes and the adoption of The Innocenti Declaration 1990 defining, protection, promotion and support of breastfeeding.

Part 2. National Intervention

The Department of Health recognise that breastfeeding is a major public health issue (DOH 2004). The Infant Feeding Survey 2000 demonstrated it is also an important equality issue with only 59 per cent of women from deprived communities initiating breastfeeding compared to 85% from higher social classes. Education was shown also to be of significant importance with 51% of women who left education at or before 16 initiating breastfeeding compared to 88% of women who continued education to 19 and over. The Government in The NHS Plan (2000) commits to supporting breastfeeding and addressing these inequalities in health with a greater emphasis in the role of the public health in committing to this priority with the response of a number of policy documents.

A Department of Health paper 'A Report Evaluating the Breastfeeding Projects 1999-2002' (later in the chapter these projects will be explored in more detail) provided evidence in a comprehensive guide 'Good Practice and Innovation in Breastfeeding' (DOH 2004) to support professionals in particular when focusing on women from disadvantaged groups. The guide addresses the deeply entrenched bottle-feeding culture within the UK and how adults and children may never see a women breastfeeding with the lack of socialisation of breastfeeding within that society (DOH 2004). The guide emphasises the importance of discussions and information on the benefits of breastfeeding to 'significant others' (DOH 2004) grandmothers and fathers who have an important influence on breastfeeding decisions particularly with harder to reach mothers (DOH 2004).

The Priority and Planning Framework 2003-06 sets out defined targets to support this movement of increasing breastfeeding initiation rates by requiring a two percentage points per year increase with a particular focus on women in disadvantaged groups.

The White Paper 'Choosing Health' (2005) the government establishes three core principles of a new public health approach;

- Giving individuals 'informed choice' about their health decisions.
- 'Personalisation' offering support in making healthy choices.
- 'Working together' promoting effective partnership across agencies and communities.

Within this strategy for health breastfeeding initiatives are supported, notably 'Healthy Start: Reform of the Welfare Food Scheme' (DOH 2005) where the voucher scheme for disadvantaged pregnant women and mothers of young children will include milk, fresh fruit and vegetables as well as infant formula.

A systematic review in 2005 was commissioned by the Health Development Agency (HDA) but published after the functions of the HDA transferred to NICE on the 1 April 2005 therefore not representing NICE guidance. The document 'The effectiveness of public health interventions to promote the duration of breastfeeding' (NICE 2005) expands on earlier findings within the HDA document 'The effectiveness of public health interventions to promote the initiation of breastfeeding' (HDA 2003). These policy documents include a systematic approach where public health, health promotion and public policy interventions as well as clinical interventions targeted at the health sector enable women to initiate and continue breastfeeding (NICE 2005).

The systematic review summary 'Breastfeeding for longer: What works? (NICE 2005) highlights that breastfeeding especially prolonged and exclusive result in the greatest health benefits but is far from practised in the UK with initiation rates and discontinuation rates around the lowest in Europe (NICE 2005). This is further added among families from lower socio-economic groups where initiation and duration rates are at its lowest, adding to inequalities and the continuing cycle of deprivation. The summary recognises that as well as society and cultural norms clinical problems and lack of organisation in the health services exist and are unprepared to support breastfeeding effectively (NICE 2005). Outlined are the 'Practices and policies that have shown to be effective /beneficial for enhancing breastfeeding' (NICE 2005) which include skilled breastfeeding peer or professional support, unrestricted feeding from birth and avoidance of supplementary fluids for babies unless medically indicated.

Part 3. Local initiatives

There is extensive research available on local breastfeeding initiatives, to create depth for the benefit of this study the following sub-headings will be addressed as follows:

i) Inequalities of breastfeeding

As part of achieving the goal of reducing health inequalities the Department of Health funded a range of infant feeding initiatives summarised in 'A Report Evaluating the Breastfeeding Practice Projects 1999-2002'. Within the literature review undertaken there are many local initiatives piloted in secondary schools as part of this project. One example is 'The Breast Benefits' project which was specifically designed to address inequalities in relation to breastfeeding by working in secondary schools within areas of socio-economic deprivation. Lockey and Hart (2003) concluded that by using an educational pack stimulated cultural change by tackling the subject of both breasts and breastfeeding with young people. Wilkinson and Greenwood (as cited in the DOH 2003) were granted school access for several discussions with a group of school children which facilitated the development of learning materials and in the project by Middlemiss (as cited in the DOH 2003) a video was produced. What became apparent to all projects was that by using visual methods facilitated exploration of cultural beliefs, attitudes and knowledge (DOH 2003).

Shaw et al (2003) by researching the attitudes of health professionals and young women in low income areas demonstrated that entire communities are dominated by the bottle-feeding culture and the rapid weight gain of a formula fed baby is believed to signify within these communities a thriving baby. There is wide recognition that 'breast is best' within these communities however the culture of embarrassment and inconvenience of breastfeeding outweigh the known benefits and as Wilson and

Colquhoun (1998) conclude in their research infant feeding intentions are socially constructed within low income societies.

A recent study based in the North of England where breastfeeding rates are the lowest in the UK, Berridge, Mcfadden, Abayomi and Topping (2005) demonstrate that the perpetuating situation today that children are denied the benefits of breastfeeding depending on economic circumstances, nationality and their mother's educational ability and age can be avoided if health care providers offer the UNICEF's recommendations, promotion, protection and support to all breastfeeding women. The study concludes that the challenge remains in accessing vulnerable women who would potentially benefit the most from breastfeeding (Berridge et al 2005).

ii) Attitudes and perceptions of breastfeeding

Recently, there have been many projects focused on attitudes and intentions towards breastfeeding during the antenatal period. As Bowling (2002) refers by understanding individuals' intentions and perceptions of health, health behaviour can be predicted. However the author recognises that there maybe a wide range of factors that the individual has relatively little control for example socio-economic. Hollins (2000) addresses this issue in midwifery practice concluding that by gaining knowledge about an individuals attitudes and providing information and support to assist choices when a change in behaviour proves difficult can help change behaviour (Hollins 2000).

A comparative study of infant feeding attitudes of expectant parents in Glasgow Scotland, Shaker, Scott and Reid (2004) use the Iowa Infant Feeding Attitude Scale to research how parental attitudes are strong predictors of choice of infant feeding. The

results indicated that parents of breastfed infants were more knowledgeable about the health benefits and nutritional superiority of breastfeeding with mothers of bottle-feeding infants still having misconceptions about breastfeeding such as women who occasionally drink alcohol should not breastfeed. Shaker et al (2004) conclude that by identifying and understanding mothers' infant feeding attitudes and their social networks breastfeeding interventions can be designed and implemented.

McConnell and Koss (2000) analyse the physical bond of nursing is often viewed as both an asset and a liability. The fear of feeling restricted and the inconvenience of breastfeeding perceived can far out weigh the benefits known (Wilson and Colquhoun 1998). Bottle-feeding is considered to be automatic and simple with the benefit of allowing freedom to leave the baby with others (Wambach and Koehn 2004).

iii) Infant feeding decisions

A study undertaken in Northern Ireland (Stewart-Knox, Gardiner and Wright 2003) where breastfeeding initiation rates are 10% lower than the rest of the UK, aimed at exploring the factors determining infant feeding decisions. By using focus groups at an antenatal clinic discussion was guided covering feeding intentions, factors determining feeding decisions, perceived costs and benefits of chosen method. The authors concluded that incompatible social-norms make it difficult for mothers to breast-feed successfully and that early cessation is largely due to the negative influences within their cultural and social environment. The issues of social isolation and embarrassment both in self and perceived in others was a major barrier implying disapproval of breastfeeding in public and the apparent lack of public facilities for breastfeeding mothers. By understanding the perceptions of pregnant women towards infant feeding

the author explored the dominant themes that socially exclude nursing mothers and deter others from breastfeeding.

By using focus groups with the Theory of Planned Behaviour guiding the questions the research of feeding decisions in disadvantaged pregnant adolescents was undertaken by Wambach and Koehn (2004). Their findings were captured by two major themes, the 'perceived behavioural control' referring to a person's belief as to how easy or difficult performance of the behaviour is likely to be (complexity of breastfeeding vs. simplicity of bottle-feeding) and the 'subjective norms' referring to the perceived social pressure to perform or not to perform the behaviour (independent choice vs. social influence of family and peers). Swanson and Power (2005) investigated the Theory of Planned behaviour by using semi-structured questionnaires to ascertain the influence of social norms on initiation and continuation of breastfeeding. The results of the study demonstrated that discontinuation of breastfeeding was subject to overall social pressure to bottle-feed and that partners influence and midwives were important influences at baseline and follow-up appointments. The authors concluded that midwives have a crucial role in communicating positive views on breastfeeding and that future interventions 'need to adopt a broad social approach, encouraging positive norms for existing and potential mothers and fathers, families and people in general' (Swanson and Power 2005 p.272)

iv.) Acceptance of breastfeeding in public places

Heath (2001) explores how the emotion of embarrassment 'lies at the heart of the social organisation of day to day conduct' (Heath 2001p.60). The author suggests that

this acts as a personal constraint on the behaviour of the individual in that society with the public response considering actions 'problematic or untoward' (Heath 2001p.60). Modesty about the exposure of a private act to public view is a major barrier to breastfeeding suggests Raisler (2000). In this study the authors analyse how breastfeeding is highly variable and individual in distinguishing between what constitutes private and public. Mothers interviewed were equally embarrassed about breastfeeding in front of others in private settings like at home as they were in public places. Stewart-Knox et al (2003) conclude similar findings but also highlight the issue surrounding embarrassment of others seeing a mother breastfeeding in public with one mother stating '*I know it is natural but I do not like it at all.... I hate to see them doing it ...and I'm a women*' (Stewart-Knox et al 2003 p.267). Smale (2001) investigates in depth this issue surrounding stigma and breastfeeding in public. The author reveals how the movement in the UK towards making designated public places breastfeeding friendly where mothers are 'allowed' to breastfeed reveals that breastfeeding is stigmatised, indicating cultural unease and the word 'allow' can reveal an 'entrenched reaction' (Smale 2001p.234).

In a qualitative study aimed at first time mothers from a low socio-economic background, Hoddinott and Pill (1999) experienced that the decision to initiate breastfeeding was more embodied by knowledge gained from seeing a relative or friend successfully breastfeed but with increasing separation of families this opportunity was decreasing.

v.) Intergenerational and cultural pressures of infant feeding

Hood, Mayall and Oliver (1999) analyse the study of intergenerational issues and suggest that this concept is critical in understanding how a childhood is constructed by the power of parents and adults within schools and communities. Shucksmith and Hendry (1998) explore how the power of the family remains of profound importance in determining a young person's health beliefs and behaviours. Ineichen, Pierce and Lawrenson (1997) discuss findings from a research of teenage mothers that their attitudes of breastfeeding often hostile stating it is 'dirty or disgusting' are probable influences from discussions with a young mothers own mother. Purtell (as cited by Ineichen, Pierce and Lawrenson 1997) found that teenagers' views on breastfeeding are shaped more by social attitudes and their family rather than awareness of its benefits. The recent study by McFadden and Toole (2006) by the use of focus groups confirm these findings that women who choose to breastfeed often reported having been breastfed themselves, or having siblings who had been breastfed. Family and friends in the study were cited most frequently to influence a woman's decision to breastfeed. If this experience of breastfeeding had been negative this would influence some women to choose bottle-feeding.

This concept is addressed further by Lavender, McFadden and Baker (2006) where views on breastfeeding were explored from the viewpoint of the family as a whole. The themes that emerged showed that breastfeeding within the family did not appear to be viewed as the normal process of life. There was a lack of breastfeeding knowledge that appeared to be overtly or covertly undermining the woman's ability to breastfeed. The findings from the study recognise that breastfeeding promotion needs to provide a

multi-layered approach proactively encouraging a positive breastfeeding culture among family members for breastfeeding women to feel supported.

In relation to breastfeeding, Rempel and Rempel (2004) examine how male partners affect the breastfeeding decision with mothers needing to gain approval and support from their partners in order for them to initiate and continue to breastfeed. As Smale (2001) suggests from a study of inner city mothers in Glasgow without partner support sanctions against breastfeeding can even occur in their own home. In a comparative study by Shephard, Power and Carter (2000) the father's attitudes towards breastfeeding were associated with the awareness and knowledge of the health benefits of breastfeeding but fathers of both bottle and breastfeeding babies were embarrassed about their partner's breastfeeding in front of non-family members. Shaker et al (2004) conclude that fathers of breastfed infants although favour breastfeeding and are more aware its nutritional superiority like fathers of bottle-fed infants are more likely than their partners to disapprove of breastfeeding in public. Ineichen, Pierce and Lawrenson (1997) conclude that although young mothers know the advantages of breastfeeding their decision to breastfeed was based on witnessing breastfeeding themselves and the powerful influences partners, mothers and peers hold on their decision.

In a comparative study between Norway and Scotland, Gerrard (2001) investigates the factors that affect the high prevalence of breastfeeding initiation and duration rates in Norway to that of Scotland where rates are one of the lowest in Europe. The findings show that the choice of infant feeding in Norway is due to the dominant cultural norm of breastfeeding that exists in that society and Norwegians have a more relaxed attitude

towards the naked body overcoming barriers of embarrassment and isolation associated to breastfeeding (Gerrard 2001).

However the author concludes that what is also unique about the Norwegian situation compared to Scotland is the fact mothers themselves took the initiative to improve breastfeeding rates themselves at grass roots level and that the incentive was not forced upon them from either the government or health professionals (Gerrard 2001). In the UK breastfeeding initiatives are top-down rather than user-led (Gerrard 2001) however since the introduction of Sure Start, literature shows there is a strong movement towards La Leche League peer support in disadvantaged communities (Latham, Kapoor, Myers, and Barnes 2006, Dykes 2005, Raine and Woodward 2003, Graffy, Taylor, Williams & Eldridge 2004, McInnes, Love & Stone 2000, Ingram, Rosser, Jackson 2004). In the UNICEF UK Baby Friendly Initiative Annual Conference 2005, Renfrew responded to the results of the NICE public consultation ‘What Works?’ (2005) and concluded that peer support has a strong ability to eradicate myths associated with breastfeeding and that the combination of education and peer support really works in improving breastfeeding rates in areas of deprivation (Renfrew 2005). In a recent evaluation of breastfeeding peer support projects Dykes (2005) illustrates that breastfeeding peer support schemes ‘offer exciting prospects for increasing breastfeeding rates while respecting diversity, ensuring exclusivity and stimulating community empowerment’ (Dykes 2005 p.29). The National Evaluation of Sure Start (NESS, Latham et al 2006) have found that areas that have adopted the La Leche League Parent Peer training show that early signs of the ‘baby friendly’ values and ethos have started to influence services and businesses in local communities, working towards tackling the ‘non-breastfeeding cultures’ (Latham et al 2006).

The written literature on breastfeeding is extensive, however during my literature review the majority of research undertaken is with mothers or during the antenatal period. Wilson and Colquhoun (1998) and Lockey and Hart (2003) have both concluded that health promotion initiatives on breastfeeding in a educational setting are appropriate and cost-effective means in which to increase acceptability of breastfeeding and work towards reducing inequalities in health (Lockey and Hart 2003). There is a need to understand the perceptions that are socially constructed in teenager's attitudes towards breastfeeding before they become pregnant (Wilson and Colquhoun 1998) as the pressure of cultural barriers (Lockey and Hart 2003) and social referents (Swanson and Power 2005) influence a mother's infant feeding decision. This is the basis of this research to understand teenage perceptions in order to deliver future programmes that increase acceptance of breastfeeding and encourage social norms for mothers to breastfeed successfully (Stewart-Knox, Gardiner and Wright 2003).

CHAPTER 3 RESEARCH DESIGN, METHOD AND ETHICS

Background

Part 1. Research Method

Part 2. Research Design

- i) Population and sample
- ii) Focus Groups
- iii) Questionnaires
- iv) Research Questions
- v) Data Collection and management
- vi) Data analysis

Part 3. Ethics

- i. Beneficence
- ii. Avoidance of Malificence
- iii. Equal Opportunity
- iv. Informed Consent and Confidentiality
- v. Technical Competence

Background

Research methods are a fundamental aspect of understanding the world of social science (May 2001). Gilbert (2001) states there are three major ingredients needed for social research; the construction of a theory, the collection of data and the design methods for gathering data (Gilbert 2001). By using these three ingredients the research process can be described.

Firstly, the construction of a theory or research question needs to be clearly formulated to provide an explicit focus for the study (Gilbert 2001). The link between theory and research is not straightforward (Bryman 2001); primarily with theory there is the danger of drifting away from the core areas addressed by the research question (Gilbert 2001), alternatively a research with no obvious connections with theory is often dismissed by social scientists as being 'naïve empiricism' (Bryman 2001 p.7) with the accumulation of facts viewed as a 'fact finding exercise' (Bryman 2001 p.8). This process linking theory and research is achieved through two routes (May 2001);

- Deduction where the theory comes before the research, by taking the data and applying a general theory to deduce an explanation (Gilbert 2001) with evidence to test or refute theories (May 2001).
- Induction where the research comes before the theory by linking a collection of facts about social life to base upon our theories (May 2001).

The second ingredient by Gilbert (2001) is the collection of data and its analysis. This is the method of converting the 'fieldwork' into an interpretation or theory (Payne and Payne 2004). Theories in understanding the social world are firmly based on the data available and as with the work of Goffman data is used to test theories (Gilbert 2001).

Data through social research is ever increasing with the government and its agencies routinely collecting information on the populations' demographic characteristics, their opinions and their values (May 2001). In health, governments are finding it increasingly difficult to improve the health of individuals and populations and need research to understand and maintain people's health in an equitable and cost-effective way (Bowling and Ebrahim 2005). In health promotion often small-scale research is used to improve practice and offer evidence to meet a health promotion need where there are limited resources available (Ewles and Simmet 1999).

Third, the design of methods for gathering data is an essential process within social research. The approach has the potential to influence policy decision-making and is therefore fundamental that the correct methods of research findings are used (Gilbert 2001). The initial research process is the distinction between quantitative and qualitative research which both constitute different approaches to social investigation (Bryman 2001). Quantitative research can be construed as a strategy that normally takes a deductive approach with the emphasis on testing theories by the use of quantification in the collection and analysis of data (Bryman 2001). Qualitative research takes an inductive approach with emphasis on the generation of theories (Bryman 2001) by the use of words seeking to interpret the meanings of people's lives in their natural setting (Payne and Payne 2004).

Part 1. Research method

The research method is the specific technique used in social research to collect data (Bryman 2001). The chosen method is assessed by the merits of any given method in how appropriately it tackles the specific research task on hand (Payne and Payne 2004). This may be for example in the form of a self-completion questionnaire, a structured interview or a focus group. The following approach was undertaken during the research process to decide upon the most appropriate method in collecting data for this specific research question.

The research question ‘Understanding teenage perceptions of breastfeeding’ is not only based on measuring attitudes and but also the beliefs, feelings and behaviour of an individual that are not always consistent with one another (Bowling and Ebrahim 2005). An attitude is most commonly defined as a ‘predisposition to behave in a particular way’ (Gilbert 2001 p.106) though as with understanding teenage perceptions of breastfeeding there is the debate of ‘attitude-behaviour problem’ where an underlying verbal attitude (as stated by respondent in a questionnaire) will not be the sole reason for non-verbal behaviour but can only be measured as a ‘behavioural indicator’ of that individuals attitude (Gilbert 2001). Attitude is often measured by using ‘Attitude Scales’ with the Likert Scale being the most common used format (Bryman 2001) or Guttman scaling the formulation of a cumulative scale (Gilbert 2001).

Health promotion frameworks are used to predict health behaviour by models such as The Health Belief Model, the Theory of Reasoned Action and the Theory of Planned Behaviour (Naidoo and Wills 2000). These models focus on the influences that form

an intention to change behaviour which is weighed against its costs i.e. an individual's susceptibility towards an illness and the severity of the consequences of not taking that action (Blaxter 1990). The Theory of Reasoned Action assess two main elements firstly, the belief that a particular outcome will occur as a consequence of the behaviour (Bowling and Ebrahim 2005) and second that subjective norms or what is expected of 'significant others' influences the individual belief of where they belong (Naidoo and Wills 2000). The Theory of Planned Behaviour incorporates another element within the model, the importance of behavioural control, emphasising that the perceived ability to carry out the behaviour is an influential factor in the decision – making (Bowling and Ebrahim 2005). Swanson and Power (2005) and Wambach and Koehn (2004) use the theory of planned behaviour to guide questions to pregnant women within focus group interviews and questionnaires on infant feeding decision-making. Consistent with the theory of planned behaviour both studies concluded that attitudes, subjective norms and perceived control were influential when choosing infant feeding methods (Swanson and Power 2005, Wambach and Koehn 2004).

This research at understanding teenage perceptions of breastfeeding aims at viewing the student's attitudes and beliefs of breastfeeding but also it questions the students about their normative standards and values of breastfeeding (Bryman 2001). The 'theoretical belief models' have been used in designing the questions on factors that influence their perceptions by addressing the issues surrounding socio-economic status, their perceived control and the influence of intergenerational normative pressures (Hood, Mayall and Oliver 1999).

The research strategy for this study is to take a deductive approach by using quantitative and qualitative methods. In the study published in the British Medical Journal, Henderson, Kitzinger and Green (2000) quantitative analysis by questionnaires is used to establish the overall frequency with which breast or bottle is portrayed and qualitative analysis by focus groups to explore the mothers' characteristics and language of infant feeding practice. Similar with other small-scale research projects on breastfeeding perceptions or behaviour the chosen method of research was to use focus groups and a semi-structured questionnaire. (Wilson and Colquhoun 1998, Ineichen, Pierce and Lawrenson 1997, Shaw, Wallace and Bansal 2003, Stewart-Knox, Gardiner and Wright 2003, Swanson and Power 2005)

Rather than conducting individual interviews focus groups have the advantage in this piece of social research of making use of the group dynamics to stimulate discussion, explore cultural values, their perceptions and beliefs (Bowling 2002). There is also the added benefit of saving time and resources and targeting a greater audience (Bryman 2001). By using the combination of focus groups and questionnaires as held in 'Breast Benefits' project (Lockey and Hart 2003) and the qualitative research of Shaw, Wallace and Bansal (2003) discussion was encouraged and attitudes and knowledge of the teenagers were gleaned to form the questionnaire. By using a self-completion questionnaire within the lecture period as opposed to a 'mail' or 'postal' questionnaire there was a greater return rate and knowledge that the students answered the questions themselves as opposed to someone else in the household (Bryman 2001).

The research was undertaken by using a self-completion questionnaire to all students within the Health and Social Care and Business department (potentially 100) within a period of six months. The questionnaires were delivered as part of the 'breastfeeding

workshop' being undertaken by the BAMBINOS (The La Leche League Peer Support group). The questionnaire focused on attaining information regarding intergenerational norms for example if the student themselves were breastfed, have they witnessed breastfeeding or has anyone in the family breastfed, deprivation by asking for postcodes and educational status was referred to by the course to which they attend.

PART 2. Research Design

The research design is the technical practice or framework used to identify the research question, collection of data and the analysis of its findings (Payne and Payne 2004).

The design process guides the execution of the chosen research method and its subsequent data by representing a structure (Bryman 2001) this is shown under the following sub-headings:

i.) Population and sample

The sample is the segment of the population that is selected for investigation (Bryman 2001). A good sample is a miniature version of the population (May 2001) though inevitably social researchers work on small sub-sets of the population that interest them (Payne and Payne 2004).

The selected sample size is often dependant on the resources available (Gilbert 2001). The main concern essentially is that the sample is large enough to be confident about the findings (Payne and Payne 2004). Through-out the literature review the majority of research papers regarding infant-feeding attitudes/perceptions/decisions were based on a low sample studies (Wilson and Colquhoun 1998, Shaw, Wallace and Bansal 2003, Ineichen, Pierce and Lawrenson 1997, Lockey and Hart 2003). The studies undertaken using a qualitative method by focus groups and interviews in particular were low with sample studies ranging from 14, (Wambach and Koehn 2004, Stewart-Knox, Gardiner and Wright 2003) 21, (Hoddinott and Pill 1999) and 26 (Shaw, Wallace and Bansal 2003).

The selected sample of this study consisted of 100 teenagers attending courses within the Health and Social Care and Business Departments. Similar quantitative studies using questionnaires the study sample, which takes into account the expected response rate from the selected sample, (Bowling and Abraham 2005) ranged from 50 (Wilson and Colquhoun 1998), 55 (Ineichen, Pierce and Lawrenson 1997), 80 (Berridge, McFadden, Abayomi and Topping 2005) and 129 (Shaker, Scott and Reid 2004). As was concluded in Berridge, McFadden, Abayomi and Topping (2005) and Shaker, Scott and Reid (2004) although the studies were focused at small groups, the findings did demonstrate that an understanding of attitudes could be determined with sufficient evidence for future breastfeeding interventions to be designed.

There is concern in social research of generalising findings from a selected sample and broadening its applicability to a wider population (Bryman 2001). As with the study by Lockey and Hart (2003) when carrying out research on a small-scale in schools and colleges it is important to understand that the findings from this sample are not representative of all young people in colleges of further education.

The selected sample are students both male and female (<100) attending the local further education college. As with the study by Shaker, Scott and Reid (2004) the research was undertaken with a convenience sample (Bowling and Ebrahim 2005) within the Health and Social Care and Business Studies departments. The age ranged between 14-21 year olds with mixed academic levels studying courses from Project Childcare to AVCE Health and Social Care.

The College is situated in a Sure Start catchment area that measured on the Index of Multiple Deprivation (IMD 2000) score as being one of the 20% most deprived wards in the county (Shropshire County PCT 2003). As with Sure Start, indices of deprivation are widely used by Governments to describe an areas socioeconomic circumstances, local health conditions and how resources can be best distributed (Davy Smith, Whitley, Dorling, and Gunnell 2001). This research used the Sure Start post-codes to determine the students' socio-economic background in order to predict if perceptions towards breastfeeding were influenced by socio-economic deprivation as addressed in other recent studies (Lockey and Hart 2003, Wambach and Koehn 2004, Stewart-Knox, Gardiner and Wright 2003, Hoddinott and Pill 1999 and Shaw, Wallace and Bansal 2003, McFadden and Toole 2006).

ii) Focus Groups

Focus groups have been increasingly used within the field of health research (Bowling and Abraham 2005). A focus group consists of around six to twelve people who meet together to express their views of a particular subject, which is defined by the facilitator (Gilbert 2001). It differs from a group discussion as the members are of equal status (Payne and Payne 2004) and are explicitly encouraged to talk to one another as opposed to answering questions in turn (May 2001). The role of the facilitator is to guide the session in a relatively unstructured way and not to be too intrusive (Bryman 2001) ensuring that the data collected is dependant upon the interaction of the group members (Gilbert 2001).

The literature review revealed that studies researching individuals' attitudes, perceptions or decisions on breastfeeding used focus groups to collect qualitative data and to develop or complement the questionnaire (Stewart-Knox, Gardiner and Wright

2003, Shaw, Wallace and Bansal 2003, Wambach and Koehn 2004 and Cronin 2003, McFadden and Toole 2006). Focus groups are able to explore issues surrounding breastfeeding such as societal embarrassment, perceived social isolation and family influences (Stewart-Knox, Gardiner and Wright 2003, McFadden and Toole 2006) in a way that may not have been possible via a structured interview (Bowling and Abraham 2005). Bowling and Abraham (2005) state that this is due to the fact that focus groups have the ability for the facilitator to ‘tap into ways in which health behaviour may be simply considered normal or aberrant’ (Bowling and Abraham 2005 p. 221). In this research, three focus groups consisting of 8-10 students were set up within the Health and Social Care department in the following groups:

- Group 1. Age 14-16 years (one male/ 9 females)**
- Group 2. Age 16 -17 years (12 females)**
- Group 3. Age 16-18 years (10 females)**

The groups were randomly selected signifying that all students within the sample were selected at random and every individual had a chance of being included (Fielding and Gilbert 2000). Unfortunately for a small-scale research of this nature in an educational setting the facilitator was unable to convene students that did not know each other as is stated in Payne and Payne (2004). It was equally difficult to engage males in the focus group (as only one participated), which is indicative of the larger proportion of females to males accessing courses within the Health and Social Care departments.

iii.) Research questionnaires

Questionnaires are a method of surveying the population and have become an invaluable source in collecting data about behaviour, attitudes, values and personal experiences (Gilbert 2001). Questionnaires are conducted mainly through, self-

completion questionnaires, the telephone survey or face-to face interviews (May 2001).

The common theme is that there is a system where everyone in the sample is asked the same questions, in the same order by technique of an interview or self-completing a questionnaire (Payne and Payne 2004). The type of questionnaire used will be often dependant on the type of the population, the nature of the research question and the resources available (May 2001).

Self-completion questionnaires have the benefit of being far cheaper and reaching a larger sample than the time and resources required for interviewing (Bryman 2001). In this small-scale research the method of semi-structured questionnaires was used as found in similar studies researching breastfeeding perceptions, attitudes and knowledge in areas of social deprivation (Swanson and Power 2005, Wilson and Colquhoun 1998, Shaker, Scott and Reid 2004, Ineichen, Pierce and Lawrenson 1997, Shephard , Power and Carter 2000).

From the findings of the focus group the questions were designed with having a clear relationship to the aims of the study (Bowling and Abraham 2005). The questionnaire focused on attaining information regarding intergenerational norms for example if the student themselves were breastfed, have they witnessed breastfeeding or has anyone in the family breastfed, deprivation by asking for postcodes and educational status was referred to by the course to which they attend.

iv.) Research Questions

The research questions had a clear relationship to the aim of the study (Bowling & Ebrahim 2005). It was understood during the design process that all questions were easily understandable by all respondents and that they had the same meaning to everyone so that comparable answers could be obtained (Payne and Payne 2004). The

questions remained simple and non-technical with short familiar words with consideration that the sample group were of mixed academic abilities (Lockey and hart 2003). The questions were structured not to cause embarrassment and sensitive questions were minimised. It is acknowledge that by asking sensitive or embarrassing questions leads to under- reporting of the attitude or a biased response with respondents generally wanting to be seen in a positive light (Bowling & Ebrahim 2005). The questions were semi-structured as with study by Swanson and Power (2005) a small number of open-ended questions enables the respondents to reply in their own words personal comments that may not have been covered by the questionnaire (Bowling 2005). The other questions were in a closed format with 'other' or 'don't know' to cover all possible answers making coding easier to classify (Payne and Payne 2004). The theme of the questions was focused on understanding the perceptions of young people towards breastfeeding and if socio-economic status or intergenerational normative pressures (Hood, Mayall and Oliver 1999) were factors that influenced their perceptions.

iv.) Data Collection and management

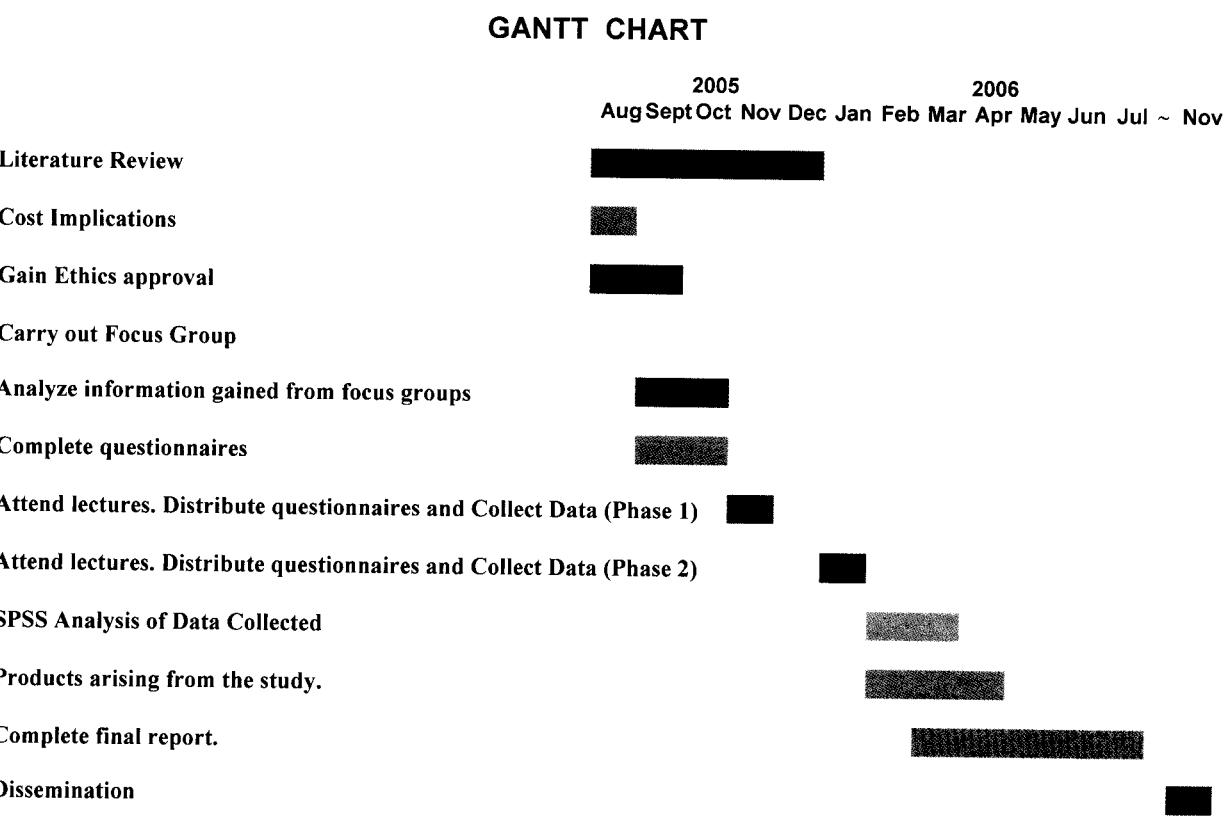
This is the method of converting the 'fieldwork' into an interpretation or theory (Payne and Payne 2004). A Gantt Chart was used as a time frame for scheduling the project tasks and controlling its progress (Ewles and Simnet 1999). The initial stage of the project during the months of August and September 2005 was gaining ethical approval and approval to undertake the research from the College.

The project was then undertaken in two phases:

- Phase1. September 2005– November 2005 carry out focus groups and analyse information.

- Phase 2. December 2005 – February 2006 distribute questionnaires and collect data.

Distributing the questionnaires were undertaken in two stages to gain maximum participation and to ensure all students within the Health and Social Care and Business study Departments were accessed.



By using the combination of focus groups and questionnaires as held in ‘Breast Benefits’ project (Lockey and Hart 2003) and the qualitative research of Shaw et al (2003) discussion was encouraged and attitudes and knowledge of the teenagers were gleaned to form the questionnaire. Focus groups as opposed to conducting individual interviews have the advantage in this piece of social research of making use of the group dynamics to stimulate discussion, explore cultural values, their perceptions and beliefs (Bowling 2002). There is also the added benefit of saving time and resources

and targeting a greater audience (Bryman 2001). The research was undertaken by using semi-structured questionnaires to all students within the Health and Social Care and Business department. By using a self-completion questionnaire within the lecture period as opposed to a 'mail' or 'postal' questionnaire there was a greater return rate and knowledge that the students answered the questions themselves as opposed to someone else in the household (Bryman 2001). The self-completion questionnaires were handed out during the lecture period. The questionnaire was accompanied with a letter to the students explaining its purpose and the nature of its contents (May 2001). It was made clear that completing the questionnaire was optional and that all the data collected was confidential. Time was allocated for the students wanting to complete the questionnaire and then the data was collected.

All information gathered was confidential according to the Data Protection Act 1998. All data collected including documentation from the focus groups was kept in a secure environment during the research process.

v.) Data analysis

The initial process of the analysis began after the first focus group with the ability to debrief any emerging patterns as was used in Wambach and Koehn (2004) and to change any questions before the next group. The following focus groups were used to discuss similarities and differences between each group according to age and academic abilities. From this analysis of the focus groups themes and categories were identified to form the questionnaire. These were structured by questions surrounding intergenerational issues (Hood et al 1999), attitudes and their perceptions of

breastfeeding. Socio-economic status was analysed by postcode and academic capabilities by the course they attended.

All the data collected at both the focus groups and the questionnaire were kept and used as the basis of the thematic analysis by using Statistical Package for the Social Sciences (SPSS V13) the leading program for managing and analysing social scientific data (Bryman and Cramer 2005). As stated by Gilbert (2001) if twenty or more questionnaires are returned the most advisable method to analyse data is through the popular and widespread software SPSS. In this research the use of cross-tabulation, the ability to find the relationship between two variables gave more 'flesh' (Bryman and Cramer 2005) to the research process. There was the ability to demonstrate if there was a relationship or not between two variables which for this type of research understanding cultural and social influences on perceptions was extremely valuable. Each cross-tabulation process is presented in a 'contingency table' (Bryman and Cramer 2005) containing four cells in which the frequencies of the variables are listed.

Part 3. Ethics

The work undertaken during the research process in health must comply with the ethical codes of practice designed to protect the rights and interests of the people actively consenting to be studied (Payne and Payne 2004). Ethical committees have become a formalised feature of health research with the national system of Local Research Ethics Committees (LREC's) set up in 1991 ensuring ethical review of all research projects involving National Health Service patients (Bowling and Abraham 2005). In this research studying 'teenage perceptions of breastfeeding' the ethical implications were considered under the RCN Research Ethical Criteria 2004.

The following headings were addressed namely:

i) Beneficence

The benefit of this research is that local practitioners will have a greater understanding of breastfeeding perceptions of teenagers from mixed socio-economic backgrounds and what knowledge they have of the benefits of breastfeeding. The outcome of the research is to be used in evidence to deliver future programmes that increase acceptance of breastfeeding and encourage social norms for mothers to breastfeed successfully (Stewart-Knox, Gardiner and Wright 2003). It is proposed that the research findings will highlight the lack of breastfeeding education within the National Curriculum currently and that by offering breastfeeding education in schools myths attached to breastfeeding can be eradicated and its acceptability can be increased (Lockey and Hart 2003).

ii.) Avoidance of Malificence

During the research process there was a duty of care to avoid harm (Naidoo and Wills 2000). The use of self-completion questionnaires is a less obtrusive research method than conducting individual structured interviews (Parahoo 1997) and response is

voluntary. The questions are based on understanding the individual's attitudes and perceptions of breastfeeding and are unlikely to cause trauma or harm. The first stage of the research process was to gain permission by the Head of Department. A formal letter was sent with a copy of the questionnaire to the head of department to gain approval and all ethical considerations were followed.

iii.) Equal Opportunity

The research follows anti-discriminatory practice acknowledging diversity, personal beliefs and values (Ewles and Simnett 1999). All students male and female attending the Health and Social Care courses are included to participate in the study and nobody will be disadvantaged in anyway.

iv.) Informed Consent and Confidentiality

An information letter was given regarding the research. By using the process of self-completion questionnaires it gives the opportunity for the students to remain anonymous throughout the research process (Parahoo 1997). However all data collected will remain confidential according to The Data Protection Act 1999.

v.) Technical Competence

The researcher is computer literate. However advice and support has been gained from University of Chester when undertaking the SPSS v13 method of analysis.

CHAPTER 4 FINDINGS AND ANALYSIS

The research question ‘Understanding teenage perceptions of breastfeeding’ is not only based on measuring attitudes but also the beliefs, feelings and behaviour of an individual that are not always consistent with one another (Bowling and Ebrahim 2005). An attitude is most commonly defined as a ‘predisposition to behave in a particular way’ (Gilbert 2001 p.106) though as with understanding teenage perceptions of breastfeeding there is the debate of ‘attitude-behaviour problem’ where an underlying verbal attitude (as stated by respondent in a questionnaire) will not be the sole reason for non-verbal behaviour but can only be measured as a ‘behavioural indicator’ of that individuals attitude (Gilbert 2001). This study at understanding teenage perceptions of breastfeeding aims at viewing the student’s attitudes and beliefs of breastfeeding but also it questions the students about their normative standards and values of breastfeeding (Bryman 2001). This chapter will be divided into the following parts:

Part 1. Findings and analysis of the focus group

Background

- i) The students knowledge of breastfeeding
- ii) The attitudes of the students when seeing breastfeeding in a public place
- iii) Factors that would influence the students to breastfeed.

Part 2. Findings and analysis of the questionnaire

Background

a.) Sample group

- ii) Gender
- iii) Age of students
- iv) Postcode to indicate level of deprivation

- v) Educational status of students

b). Perceptions of breastfeeding

- i) Culture and Intergenerational normative pressures
- ii) Acceptance of breastfeeding in public places

c.) Knowledge of breastfeeding

- i) Benefits of breastfeeding known
- ii) Influence of breastfeeding education on students perception towards breastfeeding.

d.) Limitations to the study

Part 1. Findings and analysis from the focus group

Background

The focus groups were co-ordinated by the researcher and led by two Breastfeeding Peer Supporters (BAMBINOS) who acted as facilitators, one steering the discussion and the other recording the comments as undertaken by Cronin (2003). The outcome was for the researcher to access the language, thoughts feelings and emotions of the groups and thus give more depth in the design of a more appropriate questionnaire (Bowling and Abraham 2005). The main themes that were led by the facilitators and explored from the focus groups were:

i.) The student's knowledge of breastfeeding

From discussion as was found in the 'Breast Benefits project (Lockey and Hart 2003) the students knowledge regarding the health benefits was revealed. Comments of the student's knowledge were as follows:

'Breastfeeding develops the baby's immune system'

'Less risk of the baby developing eczema'

'Helps you to loose weight'

'Less risk of developing breast cancer'

However there were many myths attached to breastfeeding comments such as:

'Will you have to still feed when the child's four? That's disgusting!'

'I wouldn't because you get saggy boobs'

'I would worry about the back strain'

'I've heard that it hurts'

Questions regarding the students' knowledge of breastfeeding were developed for the questionnaire. The focus groups indicated that the many myths or 'old wives tales'

attached to breastfeeding was a perceived barrier to the students. It was important to the research process to have a greater understanding of what knowledge the students had and if they had received any previous education on breastfeeding in primary or secondary school.

ii) The attitudes of the students when seeing breastfeeding in a public place

All focus groups viewed breastfeeding in public definitely as a disadvantage to breastfeeding. Unexpected findings from the discussions were the strong feelings of disgust in some students when seeing breastfeeding in a public place. This was in particular the view of Group 1 the younger group of students. One student narrated a story about her getting off a train and waiting 20 minutes for the next one as there was a women breastfeeding near to her. This helped develop the relevant language when designing the questionnaire. The word such as ‘disgusting’ was used and the strong attitude of leaving an area if witnessed breastfeeding nearby.

Comments recorded during the focus group were as follows:

‘It doesn’t seem right’

‘I think it’s disgusting in public’

‘I don’t think it’s polite’

‘I’d heard it was against the law to breastfeed in public in England’

‘It should only be done in the toilets’

iii) Factors that would influence the students to breastfeed.

During this discussion in all three focus groups there was a common theme that students who were breastfed (12 in total) had a more positive attitude towards breastfeeding.

The area of intergenerational normative pressures (Hood, Mayall and Oliver 1999) became a central theme within the questionnaire. As recognised in previous breastfeeding literature (Stewart-Knox, Gardiner and Wright 2003, Shaw, Wallace and Bansal 2003, Wambach and Koehn 2004 and Cronin 2003, Baldock-Apps 2006) infant feeding decisions are 'normalised' by social and cultural influences. One student expressed the importance of her and her brother being breastfed as there was a family history of asthma; this led to the students debating in greater depth the importance of the benefits of breastfeeding. As states in Bowling and Abraham (2005) the focus groups were empowering for some students with the ability for them to view their experiences and follow the social process involved in reaching an opinion about an issue. The only male in the group did find it difficult to interact making only small 'jokey' comments but he did at the end of the session state that he would encourage the mother of his baby to breastfeed now having heard of the benefits. Positive comments towards breastfeeding recorded from the focus groups were as follows:

'I was breastfed because there is asthma in the family'

'I suppose you don't have to take bottles everywhere'

'It's free'

'You loose weight'

'It helps your baby with mental ability'

'It helps you to bond'

'Good to hear there are places to go when out and about' (referring to local

Breastfeeding Friendly Premises scheme)

As in the research by Stewart-Knox, Gardiner, and Wright (2003) there were spontaneous themes that arose from the focus group discussions. There was an overall concern with the students of having to expose themselves in front of family, friends and when out in the local town. Although many of the health benefits were known the perceived physical aspects of breastfeeding were the main barriers.

In conclusion the focus groups were a useful tool to generate definite themes to which the questionnaire developed under the following sections:

- Intergenerational normative pressures towards infant feeding decisions.
- Attitudes towards breastfeeding in public
- Knowledge of the benefits of breastfeeding

PART 2. Findings and analysis from the questionnaire

Background

This chapter will now convert the ‘field work’ of the study into an interpretation or theory (Payne and Payne 2004). The data collected was analysed using SPSS V13 with the ability of using cross-tabulation to find the relationship between two variables. This chapter will outline the relationship between two variables and use as a method to support the interpretation or theory of this research (Bryman 2001). The first step of the research process is to understand each variable before the analysis explores linkages or relationships between two or more variables in the cross-tabulation process (Fielding and Gilbert 2006). The variables will be described initially by analysing the sample group. The meanings of each component in the tables are listed as follows:

Frequency: The number of occurrences that fall into each category of each variable (Fielding and Gilbert 2006).

Percent: This is the proportion of cases contained within each frequency (Bryman and Cramer 2005).

Valid Percent: This is the percentage that is reported in the analysis as it excludes any missing values in the percentage calculation (Fielding and Gilbert 2006).

Cumulative Percent: This gives the median value of the percentages or the categories that fall in middle observation. This has the advantage of showing the proportion of distribution that occurs above or below a particular percentage (Fielding and Gilbert 2006).

a) Sample Group

In total 72 questionnaires were returned from 100 (72%). Whilst this research was undertaken in one College of Further education as with the project by Lockey and Hart (2003) the researcher does not claim that this is representative of all Colleges. The College is placed in an area of socio-economic deprivation and lies within the Sure Start catchment though attract students from a wider rural area. The results from the sample group are as follows:

i) Gender

Table 1. Gender participating in the study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	18	25.0	25.0	25.0
	Female	54	75.0	75.0	100.0
	Total	72	100.0	100.0	

Findings: The findings from table 1 show that a total of 18 males (25%) and 54 females (75%) participated in the research.

Analysis: The lower percentage of males indicated the higher levels of females attending courses in the health and social care department. Also as was found in the Breast Benefits project (Lockey and Hart 2003) young men often don’t see that breastfeeding is relevant to them and are more likely to ignore health needs (Thom 2003). Taking into account these two factors a 25% response rate was as expected.

ii) Age of students

Table 2. Age Band of students

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	14 to 16	40	55.6	55.6	55.6
	17 to 19	31	43.1	43.1	98.6
	20 to 21	1	1.4	1.4	100.0
	Total	72	100.0	100.0	

Findings: Table 2 indicates that the largest age group were 14-16 year olds (55.6%) with the second largest group 17-19 year olds (43.1%). There was only one participant over 20.

Analysis: The cross section of age within the selected sample is significant in the results of the research. The age range between 14-19year olds can indicate different responses in infant feeding decision-making with attitudinal, social and perceived control factors influencing teenagers throughout their adolescence (Wambach and Koehn 2004).

iii.) Postcode to indicate level of deprivation

Table 3. No. of students living in deprivation by postcode as an indicator

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	37	51.4	52.1	52.1
	Yes	34	47.2	47.9	100.0
	Total	71	98.6	100.0	
Missing	System	1	1.4		
Total		72	100.0		

Findings: The results show in table 3 that from a sample of 71 (one participant did not know post-code) 34 lived in the Sure Start catchment and 37 although lived in the local area did not live in the wards designated 20% most deprived.

Analysis: The postcodes were used to measure the levels of deprivation by the Sure Start catchment. The Sure Start catchment is measured on the Index of Multiple Deprivation (IMD 2000) score as being one of the 20% most deprived wards in the county (Shropshire County PCT 2003). This showed that just under half of the students were living in areas of relative socio-economic deprivation or on the periphery of this area. The effect of socio-economic circumstances on the relationship of infant feeding practice is well researched (DOH 2003). Inequalities in health are demonstrated where only 56% of social class V initiate breastfeeding compared to 90% of social class 1 (Carson 2001). The UNICEF UK Baby Friendly Initiative Annual Conference (2004) reported that the health of children could be influenced by parental choice of infant feeding practice. It was reported in a recent study that children from low socio-economic backgrounds who received breast milk and received a later introduction to solid foods showed health outcomes that were similar or significantly better than the health outcomes of more affluent children who were bottle-fed and were introduced to early solid feeding (Forsyth 2004).

iv.) Education of Students

Table 4. Course attended by students

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	14-16Project Child care	11	15.3	15.3	15.3
	Certificate in Child care and Education	8	11.1	11.1	26.4
	GNVQ Health and Social Care	2	2.8	2.8	29.2
	BTEC National Diploma and Social Care	19	26.4	26.4	55.6
	Other BTEC Courses	32	44.4	44.4	100.0
	Total	72	100.0	100.0	

Findings: The findings indicate from the sample group were from mixed educational abilities. From a sample of 72 just over 70% were attending BTEC National Diploma courses with the entry requirements of 4GCSE’S the remainder were studying either GCSE’s in Child care or vocational child care courses and are unlikely to study beyond age 16.

Analysis: The level of education students achieve has a dramatic influence on infant feeding decisions. In The Infant Feeding Survey 2000 this was demonstrated with 51% of women who left full-time education at or before age 16 initiated breastfeeding compared to 88% of women who continued education to at least age 19 (DOH 2000).

b.) Perceptions of breastfeeding

i) Culture and Intergenerational normative pressures

Table 5. Percentage of Students that were breastfed, bottle-fed or mixed fed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Breastfed	8	11.1	11.1	11.1
	Bottle-fed	39	54.2	54.2	65.3
	Both	25	34.7	34.7	100.0
	Total	72	100.0	100.0	

Findings: Table 5. shows from a sample of 72 only 8 teenagers (11.1%) were exclusively breastfed. The largest proportion of students were bottle-fed 39 (54.2%) with 25 (34.7%) mixed fed.

Analysis: These results certainly demonstrate the bottle-feeding culture of the area with the combination of mixed fed and breastfed still far below the dominant bottle-feeding rates. The town where the study was undertaken has the lowest breastfeeding rates in the county (Shropshire County PCT 2005) with breastfeeding at birth by Sure Start area 53% and the average for the remaining town only rising to 57% far below the average county rate of 63%.

Table 6. Percentage of Students that plan to breastfeed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	46	63.9	65.7	65.7
	Yes	24	33.3	34.3	100.0
	Total	70	97.2	100.0	
Missing	System	2	2.8		
Total		72	100.0		

Findings: Table 5 indicates that the response rate was low with only 34.3% of all students planning to breastfeed.

Analysis: The low percentages of students planning to breastfeed are reflected in a study by Wambach and Koehn (2004). There was evidence to support that the influencing factors of infant –feeding choices by disadvantaged pregnant adolescents were due to the strong social and family influences on the adolescent’s choice of feeding method. The decisions made were from family members where there was little breastfeeding education viewing what they perceived as best, suggesting that bottle-feeding was automatic and simple and provides freedom to leave the infant with others.

Table 7. Cross-tabulation between Mother of students that Breastfed and students that plan to breastfeed

			Do you plan to breastfeed		Total
			No	Yes	
Mother Breastfed	No	Count	31	7	38
		% within Do you plan to breastfeed	67.4%	29.2%	54.3%
	Yes	Count	15	17	32
		% within Do you plan to breastfeed	32.6%	70.8%	45.7%
Total		Count	46	24	70
		% within Do you plan to breastfeed	100.0%	100.0%	100.0%

Findings: The results indicated in table 6 show there is a correlation between a teenagers mother having breastfed and the plan to breastfeed themselves. When asked in the questionnaire ‘Do you plan to breastfeed?’ Over 70 per cent of those with mothers that breastfed said ‘yes’ they would breastfeed compared to 29 per cent of those with mothers that bottle-fed.

Analysis: These findings were also shown in a study exploring the attitudes of teenage mothers as breastfeeders by Ineichen, Pierce and Lawrenson (1997). The study concluded that mothers of teenagers often influenced their daughter’s decision with infant feeding.

Table 8. Cross-tabulation of students with Mothers that Breastfed and students views on best method of feeding baby

			Best method of feeding baby					Total
			.00	Breastfeeding	Bottlefeeding	Mixed feeding	Don't know	
Mother No Breastfed	Count	1	8	13	8	9	39	
	% within Best method of feeding baby	100.0%	36.4%	81.3%	42.1%	64.3%	54.2%	
Yes	Count	0	14	3	11	5	33	
	% within Best method of feeding baby	.0%	63.6%	18.8%	57.9%	35.7%	45.8%	
Total	Count	1	22	16	19	14	72	
	% within Best method of feeding baby	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Findings: The findings indicate that if the student’s mother breastfed this influenced the teenagers’ view of what they perceived were the best methods of feeding a baby. The results in table 8 demonstrated that over 80% of teenagers with mothers that bottle-fed believed that bottle-feeding was the best way to feed a baby.

Analysis: The study by Stewart-Knox, Gardiner and Wright (2003) in Northern Ireland where low breastfeeding initiation rates are coupled with high cessation rates found that early cessation of breastfeeding is largely because of negative influences within the individuals cultural and social environment. The research showed that feeding decisions were strongly influenced by friends and family, with breastfeeding perceived as a barrier to practical support given from the family.

In the questionnaire teenagers of mothers that only bottle-fed themselves made the following comments regarding planning to bottle-feed. Beliefs regarding bottle-feeding included:

- ‘Because it’s more accepted’*(Female aged 14-16)
- ‘Most people I speak to think its best’*(Female aged 14-16)
- ‘Because I wouldn’t feel comfortable with breastfeeding’*(Female aged 14-16)

‘Because I was bottle-fed’

(Female aged 17-19)

‘As its normal to me’

(Female aged 17-19)

‘More convenient, other people can feed, more freedom.’ (Female aged 17-19)

With one comment of a teenager that was breastfed and plans to breastfeed:

‘It’s a motherly thing to do; natural instant feeding and my mother did it’

(Female aged 17-19)

The comments reflect that the teenager’s attitude in planning to bottle-feed is due to their feeling of being accepted and what they perceived as normal. Atkinson, McCarthy and Phillips (1987) assess the process of socialisation ‘where an individual learns to think and behave according to the values and norms prevalent in his society’ (Thomlinson as cited by Atkinson, McCarthy and Phillips 1987 p. 33). The family in this process is particularly important with many individuals adopting their parent’s belief systems during childhood.

During adolescence there are clearly ‘windows of vulnerability’ where teenagers are open to influence by their peers but modelling parental behaviour is the strongest socialisation process (Shucksmith and Hendry 1998).

Table 9. Cross-tabulation between students planning to breastfeed and number of times they have seen Breastfeeding

			Seen Breastfeeding			Total
			Never	Less than three times	Three or more times	
Do you plan to breastfeed	No	Count	19	21	6	46
		% within Seen Breastfeeding	76.0%	67.7%	42.9%	65.7%
	Yes	Count	6	10	8	24
		% within Seen Breastfeeding	24.0%	32.3%	57.1%	34.3%
Total		Count	25	31	14	70
		% within Seen Breastfeeding	100.0%	100.0%	100.0%	100.0%

Results: Table 9 demonstrates that from 56 out of 70 of the students had never witnessed breastfeeding or had seen breastfeeding less than 3 times. Only 24% of the students who had never witnessed breastfeeding plan to breastfeed with this figure rising to just over 32% if they had witnessed breastfeeding less than 3 times. If a student from the selected sample had witnessed breastfeeding 3 or more times this figure increased considerably to 57%.

Analysis: The study by Hoddinott and Pill (1999) support these findings. Their analysis found that the exposure to breastfeeding and influence on feeding intention and behaviour were strongly associated. If breastfeeding is witnessed as part of normal day life by both women and her family and friends the women is more likely to be more confident about her own ability to breastfeed and committed to her decision (Hoddinott and Pill 1999). This refers to the research undertaken by Wambach and Koehn (2004) where the ‘perceived behavioural control’ referring to a person’s belief as to how easy or difficult the performance of the behaviour is likely to be (complexity of breastfeeding vs. simplicity of bottle-feeding) is strongly associated. The recent award-winning programme ‘Parenting in Pictures’ aiming at increasing breastfeeding

rates among teenage parents used pictures of young breastfeeding mothers to promote the normalisation of breastfeeding among teenagers who had never seen a baby being breastfed (Baldock-Apps 2006).

Table 10. Cross-tabulation between students that plan to breastfeed and their Age Band

			Age Band			Total
			14 to 16	17 to 19	20 to 21	
Do you plan to breastfeed	No	Count	27	18	1	46
		% within Age Band	69.2%	60.0%	100.0%	65.7%
	Yes	Count	12	12	0	24
		% within Age Band	30.8%	40.0%	.0%	34.3%
Total		Count	39	30	1	70
		% within Age Band	100.0%	100.0%	100.0%	100.0%

Findings: Table 10 indicates that the teenager’s age did signify a difference in planning to breastfeed. The age group between 14-16 years 30.8% plan to breastfeed with this figure increasing to 40% in the 17-19 age band. There was an overall average of 33.3 %.

Analysis: It is repeatedly shown that teenage mothers are the most unlikely client group to breastfeed with breastfeeding rates increasing with the age of the mother (Ineichen, Pierce and Lawrenson 1997, Berridge, McFadden, Abayomi and Topping 2005). The findings from this study indicate that the figures are below the national average for teenagers initiating breastfeeding in the UK, which is currently at 46%, however it is reported that these rates remain lower in areas of socio-economic deprivation (Baldock-Apps 2006). The figures from this study although based on intention to breastfeed do show similarities to the latest breastfeeding rates in the local area. The group of mothers below 20 years initiation rates were as low as 34% in the Sure Start catchment with the rates increasing by 10% in the mothers ageing between

20-24 year olds (Shropshire County PCT 2005). The strong link in intention to feed and current initiation rates do suggest as stated by Earl (2002) that young people have often made a decision about their choice of infant feeding long before pregnancy.

Table 11. Cross-tabulation between students that plan to breastfeed and if they live in an area of deprivation as indicated by post-code

			Deprivation		Total
			No	Yes	
Do you plan to breastfeed	No	Count	21	24	45
		% within Deprivation	60.0%	70.6%	65.2%
	Yes	Count	14	10	24
		% within Deprivation	40.0%	29.4%	34.8%
Total		Count	35	34	69
		% within Deprivation	100.0%	100.0%	100.0%

Findings: Table 11 shows that the students living in deprivation and not living in deprivation were of almost equal amounts (34 and 35 students respectively). The cross-tabulation analysis between planning to breastfeed and deprivation showed that of the students living in the area of deprivation just under 30% plan to breastfeed compared with 40% of students that did not live in the defined Sure Start catchment.

Analysis: There are limitations to this study in comparing deprivation and non-deprivation areas. The Sure Start catchment is being redefined under the new Children’s Centre status with a wider catchment area being encompassed. There are many areas within the local town that lie in disadvantaged wards and have been on the fringe of the Sure Start catchment and as Davey Smith et al (2001) comments often the health needs of these areas are ignored. The town continues to have the lowest breastfeeding rates in Shropshire indicating its bottle-feeding culture (SCPCT 2004). The figures reflect that infant feeding decisions are continuing to be affected by socio-

economic circumstances and that the gap in breastfeeding inequalities does widen in the more deprived of areas.

ii) **Acceptance of breastfeeding in public places**

Table 12. Cross-tabulation between student’s belief that it is appropriate only to breastfeed in private and the gender of the students

			Gender		Total
			Male	Female	
Appropriateness to breastfeed in private	no	Count	3	21	24
		% within Gender	16.7%	38.9%	33.3%
	yes	Count	15	33	48
		% within Gender	83.3%	61.1%	66.7%
Total	Count		18	54	72
	% within Gender		100.0%	100.0%	100.0%

Findings: The results indicate that over 83% of all males and 61.1% of all females believe that it is only appropriate for a mother to breastfeed her baby in private.

Analysis: The higher percentage of males shown in Table 12 perceiving breastfeeding as a private act is also found in other studies within the UK (Stewart-Knox et al 2003, Gerrard 2001, Swanson and Power 2005, Henderson, Kitzinger and Green 2000, Shephard, Power and Carter 2000, Shaker, Scott and Reid 2004, McFadden and Toole 2006). The research undertaken by Shaker et al (2004) concluded that fathers of both breast and bottle-feeding babies strongly agreed that women should not breastfeed in a public place and they found the breastfeeding act embarrassing in front of non-family members.

As indicated in table 9 there is a deeply entrenched bottle-feeding culture in this area with the students rarely seeing or never seeing breastfeeding. Breastfeeding in public is often seen as a disadvantage to breastfeeding with bottle-feeding having less adverse

reactions and being socialised within that culture (Wilson and Colquhoun 1998). The comments made by the students in relationship to breastfeeding intentions were focused on the portrayed convenience of bottle-feeding such as:

'More easier can feed wherever you go' (Female aged 14-16)

'Because you can feed your baby everywhere and when ever' (Female aged 14-16)

'It is easier in certain situations' (Female aged 17-19)

'Because I don't think that I would feel comfortable with breastfeeding. But it doesn't bother me if other people do it'. (Female aged 14-16)

'More convenient, other people can feed more freedom' (Female aged 17-19)

These attitudes of breastfeeding in public are common perceptions among young people. Henderson, Kitzinger and Green (2000) explore the power of the media and how it helps to create or reinforce ideas about what is normal or culturally represented in Britain. The findings show that bottle-feeding was more often associated with 'ordinary' families, and less problematic than breastfeeding. The benefits of breastfeeding were rarely shown and portrayed as a method of feeding for middleclass or celebrity women. Participants in the study by Lavender et al (2006) felt that the media was able to influence attitudes towards breastfeeding but the benefits of breastfeeding were not marketed at all. Henderson et al (2000) examined how this media coverage reflects what is publicly visible, the lack of acceptance of breastfeeding in public associating breastfeeding as a difficult activity and an option for only certain types of women. In addition, Gerrard (2001) states that the aggressive marketing of formulae companies in the UK is an unethical approach by the Government with mothers who do not have the knowledge and confidence to go against cultural norms and peer pressure being the most likely group to be influenced by this promotional activity (Gerrard 2001).

Smale (2001) refers to the strong stigmatisation of breastfeeding in the UK with the cultural unease with public breastfeeding. Breastfeeding is an act to be undertaken in the public toilet or a mother should rush her distressed baby home as opposed to being seen breastfeeding in public (Smale 2001). Comments made by students to support their decision to mix feed summarised this perception;

- ‘If I’m in a public place then I would bottle-feed’*
‘I’ll breastfeed to help bond but only feed in my house’
- (Female 14-16)
(Female 17-19)

With a further strong comment made by another student stating;

- ‘Breastfeeding I think it is disgusting in a public place, at home is fine. Bottle feeding is healthier for the baby and more hygienic’*
- (Female 17-19)

Gerrard (2001) refers to how breastfeeding in the UK is less tolerated and accepted when compared to Scandinavian countries where there is amore-relaxed attitude towards the naked body. There is no feeling of embarrassment or do societal forces undermine the women’s confidence in her ability to breastfeed.

Table 13. The percentage of students that view breastfeeding as embarrassing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	57	79.2	79.2	79.2
	yes	15	20.8	20.8	100.0
	Total	72	100.0	100.0	

Findings: The findings from table 13 show that over 20% of all students found breastfeeding embarrassing.

Table 14.The percentage of students that want to leave the area when seeing breastfeeding

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	58	80.6	80.6	80.6
	yes	14	19.4	19.4	100.0
	Total	72	100.0	100.0	

Findings: Table 14 indicates that just under 20% of all students would want to leave an area if see breastfeeding.

Analysis: Tables 13 and 14 figures reflect how the modesty and physical exposure of breastfeeding to public view is a highly variable and individual perception in young women (McConnell and Koss 2000). Findings in the study by Stewart- Knox et al (2003) showed that women are embarrassed to breastfeed in public themselves but also find seeing breastfeeding even among friends and family an embarrassing act. Two comments were made by students expressing their wish to bottle-feed as it was;

‘Less embarrassing’ **(Female 17-19)**

With one student stating;

‘I don't want somebody sucking on my nipple’. **(Female 14-16)**

This sexualisation of breasts and related embarrassment in public still remains a major social barrier to breastfeeding (DOH 2004). As discussed by Heath in Giddens (2001) embarrassment provides a personal constraint on the behaviour of an individual in a society that perceives an activity problematic or untoward.

c.) Knowledge of breastfeeding

i) Benefits of breastfeeding known

Table 15. Students view of best method of a feeding baby

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	1.4	1.4	1.4
Breastfeeding	22	30.6	30.6	31.9
Bottlefeeding	16	22.2	22.2	54.2
Mixed feeding	19	26.4	26.4	80.6
Don't know	14	19.4	19.4	100.0
Total	72	100.0	100.0	

Findings: Table 15 shows that just over 30 % of the students view that breastfeeding is the best method of feeding a baby with 22% viewing bottle-feeding and 26% viewing mixed feeding as the best method. Nearly 20% did not know which the best method of feeding a baby was.

Analysis: From the findings in table 6 showing that 33% of students plan to breastfeed and the similar figure of just over 30 % of students viewing breastfeeding as the best method of feeding a baby as shown in table 15 do indicate there is a correlation between a students knowledge of breastfeeding and their plan to breastfeed. As found in Lockey and Hart (2003) there is mixed knowledge regarding the health benefits of breastfeeding among young people. Comments made by the students reflect that they do associate certain benefits with breastfeeding such as:

‘Bottle-fed babies get constipation’ (Female 14-16)

‘Because when you breastfeed you give it nutrients that protect them from diseases and also lets you bond’. (Female 17-19)

‘I have eczema in the family and breastfeeding helps to prevent against it. Also it’s more natural and you get to bond with the baby’ (Female 14-16)

‘Bottle fed babies are more likely to suffer indigestion’ (Female 17-19)

Table 16. The student’s knowledge of the benefits of breastfeeding

		no	yes	don't know	Total
Bottlefed more likely to see a doctor	Count	22	15	35	72
	%	30.6%	20.8%	48.6%	100.0%
Bottlefeeding is normal	Count	39	18	15	72
	%	54.2%	25.0%	20.8%	100.0%
Breastfed are more intelligent	Count	36	7	29	72
	%	50.0%	9.7%	40.3%	100.0%
Breastfeeding helps to loose weight	Count	19	20	33	72
	%	26.4%	27.8%	45.8%	100.0%
Bottlefed baby is happier	Count	29	8	35	72
	%	40.3%	11.1%	48.6%	100.0%
You can breastfeed and smoke and drink	Count	36	10	26	72
	%	50.0%	13.9%	36.1%	100.0%
Bottlefeeding is more acceptable	Count	15	30	27	72
	%	20.8%	41.7%	37.5%	100.0%
Bottlefed more likely to be obese	Count	18	12	42	72
	%	25.0%	16.7%	58.3%	100.0%

Findings: The table of frequencies shown in table 16 indicate that there is a mixed knowledge regarding the benefits of breastfeeding among the 72 students. Some of the more noted frequencies are:

- Less than 10% of all students are aware of the recent evidence that breastfeeding improves a baby’s intelligence (UNICEF 2006).
- Only 16% of all students know that bottle-fed babies are more likely to suffer from obesity (UNICEF 2006).
- 42 % of all students believe that bottle-feeding is more acceptable.
- Less than 28% know that breastfeeding helps the mother to loose weight (UNICEF 2006).

- Only 14% of all students think that mothers can breastfeed if they drink alcohol or smoke.

Analysis: The consistent lack of knowledge of the benefits of breastfeeding and the myths attached to breastfeeding as indicated in table 16 are common nationwide in the UK. This was demonstrated in a survey commissioned by the Department of Health and undertaken by NOP World 2004 (Community Practitioner 2005) which concluded that there appears inconsistent breastfeeding knowledge not only among women in the UK but also among health professionals such as midwives and health visitors (Simmons 2002).

As an example Shaker et al (2004) found in their study that bottle-feeding mothers were more likely to agree that a mother who occasionally drinks alcohol or smokes should not breastfeed and that their decision to bottle-feed was a genuine desire to protect their baby's health. The Breastfeeding Network (BFN) in Scotland has recently stated that:

'The effect of maternal consumption of alcohol is insignificant except at high or regular consumption levels.....Smoking whilst breastfeeding is not advised however the benefits of breastfeeding and smoking are still greater than formula feeding'

(The Breastfeeding Network 2004)

Many of the following comments made by the students supporting their decision to bottle-feed reflect the entrenched perception women have towards breastfeeding. The findings in the study by Wilson and Colquhoun (1998) support that factors such as not knowing how much milk the baby is getting and that breastfeeding is seen as painful are strong barriers towards breastfeeding. The barriers to breastfeeding perceived by the students are reflected by the following comments:

‘Then I know how much the baby has’ (Female aged 14-16)

‘I would prefer it as I would know how much the baby was getting’ (Female aged 14-16)

‘So I know how much the baby has had’ (Female aged 14-16)

‘Because it’s easier and it doesn’t hurt’ (Female aged 14-16)

‘Because it may be uncomfortable feeding’ (Female aged 17-19)

‘ Because a baby might object to being breastfed and like to bottle-feed’
(Female aged 14-16)

‘If you do both you can slowly wean the baby from the breast to the bottle’
(Female aged 14-16)

‘Bottle-feed when begins to get teeth’ (Female aged 14-16)

‘Because you have to stop and change to bottle’ (Female aged 14-16)

Table 17. Cross-tabulation between is breastfeeding good for mother and baby to bond and Gender of students

			Gender		Total
			Male	Female	
Is breastfeeding good for mother and baby to bond	no	Count	13	22	35
		% within Gender	72.2%	40.7%	48.6%
	yes	Count	5	32	37
		% within Gender	27.8%	59.3%	51.4%
Total		Count	18	54	72
		% within Gender	100.0%	100.0%	100.0%

Findings: Table 17 shows that just under 28% of all male students believe breastfeeding is good for mother and baby to bond compared to nearly 60% of all female students.

Table 18. Cross-tabulation between is breastfeeding a natural way to feed a baby and Gender of students

			Gender		Total
			Male	Female	
Is breastfeeding a natural way to feed a baby	no	Count	13	14	27
		% within Gender	72.2%	25.9%	37.5%
	yes	Count	5	40	45
		% within Gender	27.8%	74.1%	62.5%
Total		Count	18	54	72
		% within Gender	100.0%	100.0%	100.0%

Findings: The findings in table 18 show that over 72% of all the male students do not perceive breastfeeding as a natural way to feed a baby. However over 74% of all female students do perceive that breastfeeding is a natural way to feed a baby.

Analysis: The findings in table 17 and 18 show that a high percentage of all female students believe that breastfeeding is a natural way to feed a baby and that breastfeeding helps you to bond with the baby. Positive comments made by the female students support these findings:

- ‘It gives natural goodness to the baby and the statistics on breastfed babies look really good’*

(Female 17-19)
- ‘Helps bond with baby better. Better in education’*

(Female 17-19)
- ‘Because it’s natural’*

(Female 14-16)
- ‘It’s a good way to bond with the baby’*

(Female 17-19)
- ‘Because it helps you bond with your baby and become closer’*

(Female 14-16)
- ‘Because it’s natural and healthier you will be closer and it’s free’*

(Female 14-16)
- ‘Help bond but only feed in my house’*

(Female 14-16)

However the high percentages of female students 74% perceiving breastfeeding as natural and nearly 60% perceiving breastfeeding as a method to help bond with the baby indicate that these are still not strong enough determinants to encourage them to

breastfeed as is shown in table 5 where only 34% actually plan to breastfeed. Other studies (Stewart-Knox et al 2003, Shephard et al 2000, McConnell 2000) have found that young mothers perceive the physical bond of breastfeeding as an asset and a liability with the perceived lack of freedom and independence associated with breastfeeding. The study by Stewart-Knox et al (2003) found that pregnant mothers perceived a breastfed baby as more dependant and ties the mother to the home whereas bottle-feeding is seen as more practical with the ability of leaving the baby when support is available.

The students in this research expressed similar comments in their support to bottle-feed:

‘Because then they don’t see you as food and every time they see you they want to breastfeed’.

(Female 14-16)

‘Because you have to stop and change to bottle’

(Female 14-16)

Tables 17 and 18 reflect the growing concerns within the UK of how the male population perceive breastfeeding. As found in the study by Lockey and Hart (2003) young men do not consider breastfeeding relevant to them. This study showed that nearly half of all the male students commented: *‘I’m a man not applicable’* when asked about methods of feeding a baby with further comments:

‘I want to bottle-feed because I can’t breastfeed it’

(Male 17-19)

‘I feel the baby will be happier with a bottle’

(Male 17-19)

‘Because it helps the baby to understand drinking from the bottle on its own’

(Male 17-19)

Recent evidence suggests that the father’s attitude towards breastfeeding is vital in the choice of feeding method particularly in areas of deprivation (DOH 2004). Shephard et al (2000) concluded that more concerted effort should be aimed at supporting couples

in their decision to breastfeed as the father’s non-supportive or negative outlook towards breastfeeding would discourage their female partners from attempting to initiate breastfeeding.

ii) **Influence of breastfeeding education on students’ perception towards breastfeeding.**

Table 19. Breastfeeding Education received by the students

		no	yes	Total
Education recieved at primary school	Count	72		72
	%	100.0%		100.0%
Education recieved at college	Count	51	21	72
	%	70.8%	29.2%	100.0%
Education recieved at secondary school	Count	66	6	72
	%	91.7%	8.3%	100.0%
Education recieved at home	Count	65	7	72
	%	90.3%	9.7%	100.0%

Findings: The findings in table 19 show that nearly 30% of all students have received education at College. Less than 10% have received education at home and at secondary school. No students had received education on breastfeeding in primary school.

Table 20. Students’ view of should there be more information/education on the benefits of breastfeeding in primary school, secondary school and higher education.

		no	yes	Total
Breastfeeding education in primary school	Count	62	10	72
	%	86.1%	13.9%	100.0%
Breastfeeding education in secondary school	Count	11	61	72
	%	15.3%	84.7%	100.0%
Breastfeeding education in higher education	Count	19	53	72
	%	26.4%	73.6%	100.0%

Findings: Table 20 shows that nearly 85% of all students believe that the most appropriate place for breastfeeding education to be received is in secondary schools. 73% of all students believe that higher education is also an appropriate place to receive breastfeeding education with only 14% considering primary school.

Analysis: The findings in tables 19 and 20 indicate that although only 30% of all students had received breastfeeding education 85% did think that there should be more education on the benefits of breastfeeding. Comments made by the students to support their views on breastfeeding education at schools and colleges:

‘Because we would have a clearer idea of what breastfeeding is about to help make a decision.’ (Female 17-19)

‘Because teenage pregnancy is getting higher so they need to know’ (Female 14-16)

‘Because it will help in the future’ (Male 17-19)

‘In college and school there are young mothers and they need to be aware of it all’ (Female 17-19)

‘A bit in primary school. In college and school as younger teenagers are getting pregnant’ (Female 14-16)

The barriers surrounding breastfeeding education in schools as summarised in the infant feeding initiative (DOH 2003) is the challenge of bridging health and education. The curriculum is already overstretched and the benefits of breastfeeding are not being seen as an important subject despite it overcoming cultural barriers and potentially reducing health inequalities (Lockey and Hart 2003).

Table 21. Cross-tabulation between students that plan to breastfeed and Education received at college

			Education received at College		Total
			no	yes	
Do you plan to breastfeed	No	Count	35	11	46
		% within Education Received at college	70.0%	55.0%	65.7%
	Yes	Count	15	9	24
		% within Education Received at college	30.0%	45.0%	34.3%
Total		Count	50	20	70
		% within Education Received at college	100.0%	100.0%	100.0%

Findings: The findings in table 20 show that 45% of students that receive breastfeeding education at College plan to breastfeed. This compares to only 30% if no education is received. This indicates that if breastfeeding education is received at College there is a15% increase of students planning to breastfeed.

Analysis: The increase in students planning to breastfeed does reflect that breastfeeding education does have a positive impact on raising the awareness of the benefits of breastfeeding in a community dominated by a bottle-feeding culture as expressed by one student:

‘Information on breastfeeding needs to be in college because I didn’t know the benefits until a speaker came to class’ **(female 17-19)**

Other recent studies funded through the infant feeding initiative between 1999-2002 (DOH 2003) found similar positive outcomes when offering breastfeeding education in schools. The ‘Breastfriends’ project by Kirkham (2002) learnt the pupils valued the knowledge on breastfeeding and the opportunity to discuss its benefits. The ‘Breast Benefits’ project by Lockey and Hart (2002) found that pupils who were unsure about whether they would choose to breastfeed said they would now consider it.

Schools have long been regarded as an important setting for health promotion programmes (Ewles and Simnett 1999) and as is recognised by Dykes (2003) that without education and support women are carrying out a partially-learned activity when breastfeeding. Though simply addressing educational issues on the benefits of breastfeeding is not enough (Smale, Renfrew, Marshall, and Spiby 2006) as is evident this knowledge does not necessarily influence an individual's behaviour to breastfeed (Lockey and Hart 2002) by knowing the value of breastmilk.

d.) Limitations to the study

The research for this study was very dependant on the resources available. As is suggested by Payne and Payne (2004) the main concern with small-scale research is that the researcher remains confident and has the ability to support its findings. Whilst acknowledging its limitations as was found in Wambach and Koehn (2004) the study was broad enough to reach its criteria and provided a variation of qualitative and quantitative data for the analysis.

The following limitations were recognised in this study.

- The use Sure of Start postcodes (IMD 2000) to signify deprivation although useful to demonstrate students that live in the most deprived wards do not include the many students not living within the designated catchment zone but live on the periphery and belong to the same community.
- The sample size of 72 although similar in size to other research studies (Wilson and Colquhoun 1998, Shaw et al 2003, Ineichen et al 1997, Lockey and Hart 2003) does have limitations in generalising its findings and broadening its applicability (Bryman 2001).

- When carrying out small-scale research in schools and colleges it is important to understand that the selected sample cannot represent the perceptions of all teenagers within that age group.
- The findings from this study in understanding teenagers' perceptions of breastfeeding can only be defined as an 'indicator' of the student's intentions to breastfeed. As Gilbert (2001) states there is the debate of an attitude-behaviour problem where an underlying verbal attitude (as stated by a respondent in a questionnaire) will not be the sole reason for non-verbal behaviour but can only be measured as a behavioural indicator of that individuals' attitude (Gilbert 2001).

CHAPTER 5 DISCUSSION

The findings from this small scale research at understanding teenagers' perceptions of breastfeeding were not surprising in an area of social deprivation where a bottle-feeding culture is so entrenched. The value of this research however is that it has given an in depth understanding of the student's feelings, personal experiences, knowledge and emotions of what is at the root of their perceptions towards breastfeeding.

Accessing the teenagers by the use of focus groups and questionnaires gave the ability to understand the themes that were dominant factors in influencing their perceptions towards breastfeeding and whether knowing the benefits of breastfeeding through education changed this attitude.

The influences of intergenerational normative pressures were dominant factors in the student's perception towards breastfeeding (Hood et al 1999). The strong relationship between whether the students mother breastfed and their intention to breastfeed was clear as table 6 illustrated over 70% of those with mothers that breastfed plan to breastfeed compared to 29 % of those with mothers that bottle-fed. Parental influence is the strongest socialisation process during adolescence behaviour (Shucksmith and Hendry 1998) reflecting what the teenager feels is accepted and what is perceived as normal in their environment (Atkinson et al 1987).

Witnessing breastfeeding within this study was also demonstrated as being a strong influence in the student's perceptions towards breastfeeding. Table 9 reflects the bottle-feeding culture within the area with 56 out of the 70 students having never or seldom seen breastfeeding. Within the UK there exists an absence of breastfeeding exposure during the socialisation process in deprived communities (Dykes 2003).

There is now strong evidence to support that exposure to breastfeeding and feeding intention is strongly associated (Hoddinott and Pill 1999). Women are more likely to be more confident about their own ability to breastfeed and committed to their decision if see positive breastfeeding as part of normal day life by both family members and friends (Lavender et al 2006). Witnessing breastfeeding also helps to overcome the barriers that are dominated by the bottle-feeding culture (Wilson and Colquhoun 1998, Wambach and Koehn 2004) where rapid weight gain of a formula fed baby is believed to signify a thriving baby (Shaw et al 2003).

Consistent with other findings breastfeeding in public was perceived as a barrier to breastfeeding with bottle-feeding seeming more convenient having less adverse reactions such as embarrassment and exclusion (Stewart-Knox et al 2003, Gerrard 2001, Swanson and Power 2005, Henderson, Kitzinger and Green 2000, Shephard, Power and Carter 2000, Shaker, Scott and Reid 2004, McFadden and Toole 2006). As indicated in Table 11. 83% of all males and 61% of all females believe that breastfeeding was only appropriate in private. This refers to the strong stigmatisation of breastfeeding and the cultural unease with public breastfeeding in particular among men (Smale 2001).

The research findings do suggest as stated by Earl (2002) that teenagers have often made a decision about their infant feeding long before pregnancy. There is 33% of students planning to breastfeed and the current breastfeeding initiation rates of mothers below 20 in the Sure Start catchment remains at 34% (Shropshire County PCT 2005). The links in these findings do provide evidence to support this statement.

This study does reinforce the conclusions provided by the Infant Feeding Initiative (DOH 2003) that breastfeeding education in schools and colleges ‘are crucial across the country particularly in communities with low rates of breastfeeding’ (DOH 2003 p.53). An encouraging finding from this study is that the majority of students did support this view with 85% believing there should be more education on the benefits of breastfeeding in secondary schools. This study has identified that education in schools and colleges on the benefits of breastfeeding is a useful tool though it does have its limitations as indicated in table 20 with an increase of 15% on students planning to breastfeed if education is received. Previous studies (Lockey and Hart 2002, Earl 2002) have indicated knowledge does not necessarily influence a young person to breastfeed. As found in this study regardless of education received there remains the common perception that breastfeeding implies social isolation, restricted freedom and public disapproval (Stewart –Knox et al 2003).

CHAPTER 6 CONCLUSION AND RECOMMENDATIONS

The patterns that emerged throughout this research process have been previously recognised in other studies that have explored women's perceptions and attitudes towards breastfeeding (Stewart-Knox et al 2003, Gerrard 2001, Swanson and Power 2005, Henderson, Kitzinger and Green 2000, Shephard et al 2000, Shaker et al 2004, Wilson and Colquhoun 1998, Shaw et al 2003, Ineichen et al 1997, Lockey and Hart 2003, McFadden and Toole 2006, Lavender, McFadden and Baker 2006). Recent studies have focused on women during the ante and postnatal period with few having explored teenagers' perceptions towards breastfeeding prior to pregnancy. It is recognised that the UK has one of the lowest breastfeeding rates in the developed world (Earl 2002) and certainly the lowest in Europe (Fairbank 2004) with the bottle-feeding culture entrenched by socio-economic deprivation, geography, cultural background and education (Shaw et al 2003).

This research aimed at understanding the entrenched perceptions of breastfeeding that are socially constructed in teenagers before they become pregnant (Earl 2002) as the pressure of cultural barriers and social referents influence their infant feeding decision (Swanson and Power 2005, Lockey and Hart 2003). The use of focus groups and questionnaires generated themes from qualitative and quantitative data to not only measure attitudes but also question the students of their beliefs, feelings, values and normative standards of breastfeeding (Bryman 2001).

The main themes that emerged from the study are as follows:

- There was a significant increase of students planning to breastfeed if their mother breastfed.

- There is a strong relationship between students planning to breastfeed and the number of times breastfeeding is witnessed.
- The gap in breastfeeding inequalities does widen in the more deprived areas.
- Breastfeeding in public is seen as a disadvantage to breastfeeding and generally not accepted.
- There is inconsistent knowledge of the benefits of breastfeeding.
- Half of the male students did not consider breastfeeding relevant to them.
- Breastfeeding education can help to change attitudes towards intentions to breastfeed.
- Students do believe that there should be education on the benefits of breastfeeding in secondary schools.

Using teenagers as the sample group from an area of low income has offered an insight to the local barriers to breastfeeding. Young people's views are not consulted on a routine basis but can offer value in future planning in health interventions (Curtis, Liabo, Roberts and Barker 2004). The teenage years are associated as a time of risk-taking behaviour yet it is also a crucial time for laying down the foundations for future health (Bekaert 2003) while lifetime habits and attitudes are acquired (Naidoo and Wills 200). Consistent to other studies (Ineichen et al 1997, McFadden and Toole 2006, Lavender et al 2006, Baldock-Apps 2006) this research suggests that cultural and intergenerational norms such as witnessing positive breastfeeding and having a mother that breastfed influence infant feeding decisions. The students' feelings of disgust and embarrassment associated with breastfeeding in public signify further stigmatisation of breastfeeding and cultural unease (Smale 2001).

The encouraging finding from this study was the overwhelming majority of students that believed there should be education on the benefits of breastfeeding at secondary

schools. Wilson and Colquhoun (1998) and Lockey and Hart (2003) have both concluded that health promotion initiatives on breastfeeding in a educational setting are appropriate and cost-effective means in which to increase acceptability of breastfeeding and work towards reducing inequalities in health. Evidence supports that health promotion interventions that target children and young people can lay foundations of a healthy lifestyle that is sustained into adulthood (Licence 2004).

The Government is committed to supporting breastfeeding and addressing the inequalities in health that exist (DOH 2000) and recognise there is a lack of socialisation of breastfeeding within our society (DOH 2004). The systematic review 'The effectiveness of public health interventions to promote the duration of breastfeeding' (DOH 2005) recommends that to change the embedded thinking and behaviour of several generations of practitioners and society as whole towards breastfeeding require a coordinated approach including support within the school curriculum.

The basis of this research is to understand teenage perceptions in order to recommend future programmes that increase acceptance of breastfeeding in areas of deprivation and encourage a positive breastfeeding culture where mothers are able to breastfeed successfully (Lavender et al 2006). Consistent to other studies there is a need to address the lack of breastfeeding knowledge and myths that are attached to breastfeeding (McFadden and Toole 2006) as without this awareness women are carrying out a partially-learned activity when breastfeeding (Dykes 2003). Schools have long been regarded as an important setting for health promotion activity (Ewles and Simnet 1999) and as found in the Infant Feeding Initiative (DOH 2003), although

there is a challenge in bridging the gap between health and education (Lockey and Hart 2003) the knowledge gained by the pupils and the opportunity to discuss the benefits of breastfeeding was valued and positively evaluated (DOH 2003).

However simply addressing education is not enough. If the Department of Health plan to meet their goals of increasing breastfeeding initiation by 2% annually and reduce inequalities (DOH 2002) there is a need to address the negative perceptions of breastfeeding in deprived societies where a women's decision to breastfeed is undermined by family and societal influences (Lavender et al 2006). Strategies should be in place to improve better facilities for breastfeeding in public so that breastfeeding is seen, supported and viewed as part of the normal process of life (Lavender et al 2006).

Finally, I would like to spend a few moments to reflect upon my experience of conducting this research dissertation. The main contribution to the study was the ability to access teenagers who offered such varied and strong attitudes towards breastfeeding. The initial concerns of would the teenagers perceive breastfeeding as relevant to them were certainly resolved by the powerful comments made by the students during the focus groups where strong attitudes of disgust towards breastfeeding were shown. Breastfeeding as a subject gave excellent use of being able to understand inequalities where the social constructs of poverty are so embedded. This study highlighted that promoting breastfeeding like so many health promotion interventions battle against powerful societal forces that have been entrenched through generations.

The experience of undertaking this dissertation has certainly broadened my skills and understanding of the complex world of social research. I have gained more confidence which is attributed also to my Supervisor and found the process very self-rewarding. I certainly now feel able to develop the research skills gained and use within my own professional practice to further my career in health promotion.

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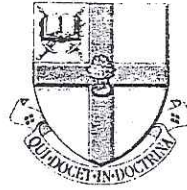
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Dear Rebecca

I am pleased to inform you that Professor Ellis has taken Chairman's action on behalf of the Research Ethics Sub Committee of the School of Health and Social Care to approve your project "Understanding teenage perceptions towards breastfeeding: A study of College students using focus groups and questionnaires".

Approval is subject to the following conditions.

1. That you provide a brief report for the sub-committee on the completion of your project.
2. That you inform the sub-committee of any substantive changes to the project.

May I take this opportunity to extend the best wishes of the Sub Committee and its Chairman for the successful completion of your project.

Yours sincerely

09 February 2006

Perceptions of Teenagers towards breastfeeding

Dear Sure Start,

This is to confirm that I am happy to support Rebecca Jones in her Masters Degree for Health Promotion. I understand that this will involve asking students to complete questionnaires about their perceptions towards breastfeeding and visiting students in college to discuss this subject

Yours Sincerely,

Christine Matthews

Curriculum Team Leader

silkenquiries@wnsc.ac.uk Website: www.wnsc.ac.uk

Principal/Chief Executive: Ron Pugh MSc MBA FRSA FIMgt Cert Ed



Information regarding this questionnaire

Dear Students,

I am currently undertaking a study as part of my Masters in Health Promotion on the perceptions of teenagers towards breastfeeding. I work for Sure Start as a Health Projects Worker and the main focus of my role is to increase breastfeeding initiation rates in the Oswestry area.

In the UK breastfeeding rates are lower than anywhere else in Europe (DOH 2004) and even though breastfeeding is commonly known to be of benefit to babies the majority of the British population bottle-feed from six weeks old. The government see breastfeeding as a major public health concern and are keen to understand the reasons why women choose not to breastfeed.

This study is aimed at exploring your views on breastfeeding and your awareness of the benefits of breastfeeding, at present there is no formal education regarding breastfeeding in our schools or Colleges. All responses will remain anonymous and confidential.

If you require further information regarding this study then please ask your supervisor and I would be glad to discuss this with you.

Thank you for your time and support

Rebecca Jones

Student’s knowledge and understanding of breastfeeding

I would be grateful if you could complete this questionnaire. It will take you about 10-15 minutes to complete. Thank you for your cooperation.

PART A: These questions are about you

1. Are you? Male ☐ Female ☐ please tick

2. What is your age? Please tick.

a. Under 14

☐

b. Between 14 – 16

☐

c. Between 17 – 19

☐

d. Between 19 – 21

☐

e. Over 21

☐

3. Do you know your postcode? If yes please complete.

_____ / _____

4. How many people live with you? Please number in the boxes provided.

a. Adults

☐

b. Sisters

☐

c. Brothers

☐

d. Your children ☐ e. Other (please give details) _____

5. Which course do you attend? Please tick

a. 14-16 Project Childcare ☐

b. Certificate in Childcare & Education ☐

c. Diploma in Childcare & Education ☐

d. GNVQ Health & Social Care ☐

e. BTEC Nat Dip in Care ☐

f. AVCE Health & Social Care ☐

g. Other (Please give details) _____

PART B: Your views on breastfeeding

6. Do you know if you were – Tick which applies

a. Breastfed? ☐ b. Bottle-fed? ☐ c. Or Both? ☐

7. Do you know if anyone in your family has breastfed or currently breastfeeds? Please tick.

a. Mother ☐ b. Sister ☐ c. Cousin ☐

d. Aunt ☐ e. Brothers partner/wife ☐

f. Other (please give details) _____

8. How often have you seen a mother breastfeed her baby?

- a. Often ☐
- b. less than three times ☐
- c. Never ☐

9. Do you think it is appropriate for a mother to breastfeed her baby in the following public places?

- | | YES | NO |
|---|--------------------------|--------------------------|
| a. A café/ restaurant | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On Public transport i.e. a bus/train | <input type="checkbox"/> | <input type="checkbox"/> |
| c. In the park | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In a public building i.e. library | <input type="checkbox"/> | <input type="checkbox"/> |

OR

- e. Only breastfeed her baby in private ☐
- f. Other (please give details)

10. What are your thoughts when you see a mother breastfeed? Please tick all that apply to you

- a. A natural way to feed her baby ☐
- b. Disgusting ☐
- c. Good for mother and baby to bond ☐
- d. Embarrassing ☐
- e. You want to leave the area ☐
- f. Interested and would like to know more about Breast feeding ☐
- g. No thoughts ☐
- h. Other (please give details) _____

PART C: What you know about breastfeeding

10. Which do you think is the best method of feeding a baby?

- a. Breastfeeding ☐
- b. Bottle-feeding ☐
- c. Mixed feeding ☐
- d. Don't know ☐
- e. Other (please give details) _____

11. Have you received any education / information on breastfeeding?

- a. At primary school ☐ b. At secondary School ☐
- c. At college ☐ d. None ☐
- e. At home ☐
- f. Other (please give details) _____

12. Do you think breastfeeding helps you to bond with your baby? Please tick

- a. Yes ☐
- b. No ☐
- c. Don't know ☐
- d. Other (please give details) _____

13. Do you think the following statements are true or false?

a. Breastfeeding helps to decrease the risk of sudden Infant death	True/False/Don't Know
b. A bottle-fed baby is more likely to see a doctor or other health professional	True/False/ Don't Know
c. Bottle feeding is the normal way to feed your baby	True/False/ Don't Know
d. Breastfed children are more intelligent	True/False/ Don't Know
e. Breast feeding helps you to loose weight	True/False/ Don't Know
f. A bottle- fed baby is a happier baby	True/False/ Don't Know
g. You can breastfeed if you smoke or drink alcohol	True/False/ Don't Know
h. Bottle- feeding is more accepted by family and friends	True/False/ Don't Know
i. Breastfeeding helps you to bond with your baby	True/False/ Don't Know
j. Bottle-fed babies are more likely to suffer from obesity later in life	True/False/ Don't Know

14. Do you plan

	Yes	No	
a. To breastfeed your baby?	<input type="checkbox"/>	<input type="checkbox"/>	If yes why?
<hr/> <hr/> <hr/>			
b. To bottle-feed your baby?	<input type="checkbox"/>	<input type="checkbox"/>	If so why?
<hr/> <hr/> <hr/>			

c. Don't know? _____

15. Breastfeeding gives the following health benefits to your baby, which if any, might encourage you to breastfeed?

- a. Protect your baby against diarrhoea, gastroenteritis & tummy upsets ☐
- b. Lower their risk of Diabetes. ☐
- c. Protects your baby against ear infections ☐
- d. Helps to decrease the likelihood of sudden infant death ☐
- e. Helps with mental development. ☐
- f. Achieves better mouth formation & straighter teeth. ☐
- g. Protects against chest infections, wheezing & Asthma. ☐
- h. Helps to prevent against childhood obesity ☐

16. Would any of these factors encourage you to breastfeed?

- a. Breastfeeding helps you to lose weight ☐
- b. To bond with your baby ☐
- c. The cost of bottle-feeding ☐
- d. If your friends were breastfeeding ☐
- e. Comfortable and private places to breastfeed when in town. ☐
- f. To contact a breastfeeding peer supporter for advice and support ☐

g. Other (Please give details) -----

17. Do you think there should be more education/ information on the benefits of breastfeeding?

- | | Yes | No |
|-------------------------|--------------------------|--------------------------|
| a. In primary school? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In secondary school? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. In higher education? | <input type="checkbox"/> | <input type="checkbox"/> |

d. If you have ticked no to any of the above then please tell me why?

Thank you for completing this questionnaire. Your response is valuable to this research.